What do people who have undertaken psychological therapy for their mental health think about therapists who disclose their own mental health difficulties during therapy?

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Acknowledgments

I dedicate this work to my beautiful daughter, Savannah. You are too young to fully understand the meaning of these words, but I will always do everything in my power to ensure you are loved unconditionally, protected and I am the best role model I can be for you. You have made me a better person, mother and psychologist. I love you dearly.

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Thesis Overview

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Orientation to the area of study

The value of personal experience with mental health difficulties is recognised in policy and is increasingly encouraged in practice (Repper, 2013). Despite this, silence around mental health professionals sharing their own mental health difficulties remains a cause for concern, even though evidence suggests those entering such a profession often do so because of their own experiences (Barr, 2006; Sussman, 2007). Narratives in this area are further complicated by the 'experts by experience' concept, which paradoxically plays into a 'them and us' divide (Richards, 2010), locating 'difficulties' in the other, and failing to recognise therapists' own vulnerabilities (Gough, 2011).

Historically, therapists sharing personal information about one's self, known as therapist self-disclosure (TSD) was primarily influenced by the therapist's theoretical orientation, with some models (e.g. psychodynamic) arguing that it can impede treatment (Curtis, 1982) by distorting the client's transference and therefore affecting its resolution (Peterson, 2002). Current thinking is converging across theoretical orientations in suggesting that TSD has potential benefits, if used carefully (Eagle, 2011). Regardless of therapist theoretical orientation, both self-stigma and fear of negative evaluation appear to be important factors in therapists' reluctance to speak openly about their own difficulties.

Research suggests there are both positive and negative aspects of therapists sharing their own mental health difficulties (Audet and Everall, 2010; Levitt et al, 2016; Wells, 1994). Exploring how the therapist's own clients view this, may help facilitate a greater understanding around personal perspectives on self-disclosure, particularly relating to the perceived interpretations made by others. It may also enhance understanding about what, how and when to share information that may be helpful to disclose during therapy.

Therapists have reported feeling more comfortable sharing their own psychological distress with clients than with colleagues or peers (Wright, Seltmann, Telepak & Matusek, 2012). Recent research has suggested that TSD of a therapist's own difficulties in such services is considered more acceptable and viewed as beneficial if done appropriately, with further research needed into TSD for wounded therapists experiencing other mental health difficulties (Cvetovac & Adame, 2017).

The narrative review (Chapter 1) endeavoured to explore the existing research relating to clients' experiences of TSD using a range of literature, including published and unpublished studies, case illustrations and review articles. It aimed to synthesise such literature to develop a greater understanding of clients' needs, wishes and views pertaining to TSD to inform current practice and guidance for therapists when considering disclosure decisions.

The empirical paper (Chapter 2) addressed the paucity of research in the area relating to clients' experiences of TSD of personal and sensitive information, specifically a mental health condition. The reasons for this were two-fold; firstly, to gain an understanding of what people who have had psychological therapy for their own mental health thought about therapists who have experienced their own mental health difficulties, and secondly, how they felt about their therapist sharing this with them during therapy. A qualitative methodology was employed to capture such experiences. Participants provided rich accounts relating to their experiences of their therapist's disclosure, the impact on the therapeutic alliance and self, and specifically their views on therapists with mental health difficulties, including pre-exiting assumptions and how they conceptualised the identities of their therapist as both a professional and person.

The target journal for both papers is the Journal of Mental Health. The chapters comply with the author guidelines for this journal (Appendix A).

References

Audet, C.T., & Everall, R.D. (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective. *British Journal of Guidance and Counselling, 38,* (3), 327-342.

Barr, A. (2006). *An investigation into the extent to which psychological wounds inspire counsellors and psychotherapists to become healers, the significance of these wounds on their career choices, the causes of these wounds and the overall significance of demographic factors*. Retrieved from http://www.thegreenrooms.net/wounded-healer.

Curtis, J. M. (1982). The effect of therapist self-disclosure on patients' perceptions of empathy, competence and trust in an analogue psychotherapeutic interaction. *Psychotherapy: Theory, Research & Practice*, *19*, (1), 54.

Cvetovac, M.E., & Adame, A.L. (2017). The wounded Therapist: Understanding the Relationship Between Personal Suffering and Clinical Practice. *The Humanistic Psychologist, 45,* (4), 348.

Eagle, M. N. (2011). *From classical to contemporary psychoanalysis: A critique and integration*. New York, NY: Routledge.

Gough, M. (2011). Looking after your pearls: The dilemmas of mental health self- disclosure in higher education teaching. *The Journal of Mental Health Training, Education and Practice, 6,* (4), 203-210.

Levitt, H., Minami, T., Greenspan, S., Puckett, J., Henretty, J., Reich, C., & Berman, J. (2015). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly*, *29*, (1), 7-28.

Peterson, Z.D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training, 30*, (1), 21-31.

Repper, J. (2013). *Briefing Paper 7. Peer Support Workers: A Practical Guide to Implementation*, ImROC, London. Retrieved from https://imroc.org/resources/7-peer-support-workers-practical-guide-implementation.

Richards, J., Holttum, S., & Springham, N. (2016). How do "mental health professionals" who are also or have been "mental health service users" construct their identities. *SAGE Open, 6*, (1), 1-14.

Sussman, M. B. (2007). *A curious calling: Unconscious motivations for practicing psychotherapy*. Jason Aronson.

Wells, T.L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work, 65*, (1), 23-41.

Wright, M.O., Seltmann, L., Telepak, L.C., & Matusek, J.A. (2012). *Therapists as wounded healers: the impact of loss and past psychological problems on work with clients*. Manuscript in preparation.

Chapter one: Literature Review

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How can clients' views and experiences of therapist self-disclosure help therapists to understand what personal information may be helpful to share about themselves with their clients during therapy? A Narrative Review.

Abstract

Background: This review synthesises research on clients' experiences of therapist self-disclosure (TSD). There remains uncertainty and disagreement between professionals regarding TSD, yet, research to date has largely neglected clients' perspectives.

Objectives: The purpose of this narrative review is to critically examine research into client perspectives of TSD, to guide and inform therapists when making disclosure decisions within therapy. Increasing understanding of how clients experience TSD may enable therapists to use it effectively as part of the therapeutic process.

Method: This review adopts a narrative approach, employing a systematic overview of the literature using defined search terms and inclusion/exclusion criteria and additional hand searching.

Results: Studies are methodologically diverse and lack ecological validity. Whilst few use real therapy clients, those that have are not culturally diverse, with cultural differences having a significant impact on therapeutic interactions, including TSD. TSD of personal information should be congruent with clients' experiences, presentation during session, appropriately timed and consideration given to the strength of the therapeutic alliance. TSD should be considered within the wider context of cultural competence.

Conclusions: A need for future research that explores clients' experiences of their therapists sharing different types of personal information, both in content and intimacy, is highlighted.

Keywords: Therapist self-disclosure (TSD), clients' perspective, cultural considerations, mock therapy, real therapy

Background

The therapeutic relationship is a fundamental aspect of therapy (Sparks, Duncan & Miller, 2008), influenced by client and therapist contributions (Castonguay, Constantino, & Holteforth 2006). There has been much debate regarding the use of therapist contributions through self-disclosure as a form of therapeutic intervention (Audet & Everall, 2010) and as Bloomgarden & Mennuti (2009) note, people have different views on, and ideas of what TSD is.

Whilst TSD significantly affects the therapeutic alliance (Ackerman & Hilsenroth, 2001; Hanson, 2005) which is the best predictor of therapeutic outcome (Horvath & Symonds, 1991), this is an area of ambiguity from an ethical guideline (Domenici, 2006) and training perspective in its use (Beutler, Crago & Arizmendi, 1986). This has led to professional disagreement, with some discouraging the use of TSD, others endorsing it (Audet & Everall, 2010), and some feeling anxious around using it. Additionally, discrepancy exists between therapist and client views of TSD (Hill et al., 1988) and, as Goz (1975) noted, "What is 'personal' to the patient may be very different to what is 'personal' to the therapist" (p.439).

Recent initiatives around self-disclosure of health professionals' own personal difficulties through guidance such as the 'Honest, Open and Proud' programme developed in the United States and being used in the United Kingdom (Scior, 2017), makes this review politically timely. TSD has attracted much theoretical debate, yet little is known about its usefulness and influence on the therapeutic relationship. Despite a growing interest in this area, little attention has been given to clients' experiences of the therapeutic relationship more generally (e.g. Bedi, 2006, Bedi, Davis & Williams, 2005), as opposed to their experiences of TSD (Audet, 2011).

Defining Therapist Self-Disclosure

The literature on TSD distinguishes between immediate/interpersonal statements; feelings about the client, therapeutic relationship or that is a response to an 'in session' event (McCarthy & Betz, 1978); and non-immediate, intrapersonal and self-disclosing statements; information about the therapist's personal life, beliefs, attitudes or values (Audet, 2011). Other forms of TSD may include non-verbal information, for example attire, race, gender and information posted in social media forums (Zur, Williams, Lehavot & Knapp, 2009). Whilst immediate TSD is used as a part of the therapeutic process and to develop the client's awareness of their behaviour (Knox & Hill, 2003) and interpersonal processes (Tantillo, 2004), non-immediate disclosure aims to develop rapport and strengthen the therapeutic relationship by demonstrating the therapist's fallibility or empathy (Edwards & Murdock, 2004).

Despite TSD composing only 3.5 percent of therapist interventions (Hill & Knox, 2001), contemporary therapists view self-disclosure as an integral part of the therapeutic relationship (Farber, 2006), with over 90 percent of therapists using either non-immediate or immediate self-disclosure. Although the latter is most commonly used (Anderson & Anderson, 1989; Levitt et al, 2016), this may be context dependant (Zur, 2011). For example, therapists working in eating disorder (Picot et al, 2010), substance misuse (Ham, LeMasson & Hayes, 2013) or military veteran services (Stricker & Fisher, 1990) are more likely to use non-immediate disclosures that reveal something personal about themselves.

Theoretical Perspectives on Therapist Self-Disclosure

Theoretical Orientation.

Historically, traditional psychoanalysts advocated against TSD, believing it would adversely affect therapeutic progress through interference in transference processes (Curtis, 1982; Freud 1958a, 1958b; Rothstein, 1997), although they have become open to exploration around its use (Myers & Hayes, 2006). In other therapies TSD is used varyingly, from providing corrective emotional experiences in relational modalities (Bridges, 2001), to demonstrating therapist fallibility and humility in humanistic approaches (McConnaughy, 1987; Rogers, 1961), providing clients with a sense of shared experience and normalisation of their difficulties (Chelune, 1979; Mathews, 1988; Yalom, 1975). Providing information about themselves as part of the therapeutic process is said to create authenticity and transparency, believed to be a central element for an effective therapeutic relationship (Breckbill, 2014).

Similarly, feminist perspectives endorse self-disclosure to reduce power differentials and promote equality as an agent for facilitating change (Brown & Walker, 1990; Nahon & Lander, 1992; Mahalik, Van Ormer, & Simi, 2000) through the 'real relationship', known as the personal or transference free part of the relationship that exists naturally (Gelso and Carter, 1994). Disclosing of the therapist's own bias, experiences or identities, provides the client with a context as to whether the therapist will be able to provide unbiased and non-judgmental support (Brown and Walker, 1990).

Cognitive Behavioural Therapists utilise TSD by way of modelling (disclosing) helpful thoughts and behaviours (Goldfried, Burckell & Eubanks-Carter, 2003; Knox, Hess, Petersen & Hill, 1997) that the client may wish to use (Simon, 1988). Similar to humanistic approaches, in CBT TSD is also endorsed by means of creating a warm, empathic connection with clients to establish reciprocity (Carew, 2009) with self-involving disclosure being utilised to help clients understand their impact on others (Sturges, 2012).

Ethical Issues.

Whilst little guidance exists from regulatory and professional bodies around the use of TSD, the British Psychological Society's (BPS, 2018) Code of Ethics states; "psychologists should consider maintaining personal and professional boundaries" (p.8) in order to uphold professional integrity. The Health and Care Professions Council's Standards of Practice (HCPC, 2016) says that relationships with service users and carers ''must be kept professional'' (p.8) although no further definition is offered as to what constitutes 'professional'. Such guidance is ambiguous in the context of TSD which reveals personal information about the therapist, and may or may not be considered indicative of a more 'personal' relationship. Likewise, it states that professionals must not do anything which could put the safety of a service user at an unacceptable risk. However, although therapists may be well intended when considering disclosure decisions, the impact of a disclosure on a client can never be fully known, and therefore not without risk.

Therapeutic Boundaries.

When considering potential ethical implications surrounding TSD, perhaps a greater understanding can be gained from an exploration of therapeutic boundaries which provide clarity around expectations of the therapeutic relationship (Smith & Fitzpatrick, 1995). There is an implicit agreement that the client's life will be the focus of therapy (Wells, 1994), where the client is permitted to explore things they may not in everyday social interactions because of how this may affect the other person (Kahn, 1991). This creates power differentials inherent within the therapeutic relationship dictating who shares what; primarily the client discloses to the non-disclosing therapist (Farber, 2003).

Some view the sharing of information about the therapist's personal life as a boundary crossing, defined by Risen (2016) as "when the therapist or the patient says or does

something that falls outside the structure of the prototypic therapeutic relationship. The therapist shares something about her personal life, or accepts a gift, or loses his temper" (p.23).

The topic of TSD and therapeutic boundaries has attracted much academic debate (Ziv-Beiman, 2013). Critics argue that therapists who share personal information about themselves risk shifting the attention away from the client (Ziv-Beiman, & Shahar, 2016), eliciting feelings of needing to care for the therapist (Audet, 2011; Peterson, 2002) and stepping outside of their professional role by replicating relational dynamics indicative of a friendship (Zur, 2007). All of these have the potential to alter the client's expectations of therapy and therapeutic processes (Barnett, 1998). Clients may be reluctant to share their feelings with the therapist (Curtis, 1981; Roberts, 2005) and feel burdened or angered by the therapist's disclosure (Matthews, 1988; Henretty & Levitt, 2010).

Equally, according to some feminist proponents (Brown, 1994), adhering to strict boundaries of non-disclosure positions the therapist as 'expert', perpetuating power differentials between the client and themselves (Van Voorhis, 2017), whilst the sharing of personal information by the therapist leads to a balance of power within the therapeutic relationship (Kaschak, 2016). Others advocate for TSD particularly when the therapist's views conflict with the client's on sensitive issues, such as religious beliefs (Hawkins & Bullock, 1995) or sexuality (Mahalik, van Ormer & Simi, 2000).

Client Perspectives of TSD

Whilst client perspectives of TSD within the academic and professional fields are sparse (Audet, 2011), because studies mainly focus on clinician views (e.g. Mathews, 1988; Simi & Mahalik, 1997; Simone, McCarthy & Skay, 1998), research has shown a discrepancy between what clients and therapists believe is acceptable to disclose. Whilst therapists are

most likely to share their qualifications and least likely to share their feelings (Edwards & Murdock, 1994), clients have indicated an interest in their therapist's feelings and coping strategies (Hendrick, 1990). This suggests that without sufficient research exploring the views of clients whose therapists have self-disclosed, therapists may risk using self-disclosure inappropriately or incongruently with their client's needs and wishes. Historically, studies exploring clients' perspectives have either used mock therapy settings (analogue studies) or real therapy clients, with there being a paucity of literature surrounding the latter.

Methods

This review adopts a narrative approach, allowing for a wide range of literature, including qualitative and quantitative literature, case studies and grey literature. Adopting a narrative approach should acknowledge the views of a diverse range of stakeholders, notably healthcare recipients (Glasby & Lester, 2005).

The review was initially characterised by clarification of working definitions and conceptual boundaries of a topic area, including a systematic overview of the literature as described below. Additional hand searches were then carried out, firstly by reviewing the reference list of each of the papers identified through the systematic review, then searching other resources, such as Google Scholar, book chapters and online articles.

Search strategy

The following databases were included in the initial search: PSYCHINFO, Academic Search Complete, PubMed, Web of Knowledge, CINHAL, ProQuest Dissertations and Thesis. The search terms used were "Self-disclosure*" OR "self-disclosure*" OR "personal disclosure*" OR "personal-disclosure*", therapist* OR psychologist* OR counsellor* OR psychotherapist*, perspective* OR experience* OR view*, patient* OR client* OR "service-

user*" OR "service user*". Searches were carried out during March 2018, with the final search being completed on 23rd March 2018. As displayed in the PRISMA flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) in Figure 1, 30 articles were identified and reviewed for suitability. Six articles met the inclusion criteria and were included for review. An additional two articles were selected through hand searching the reference lists from relevant articles.

Inclusion and Exclusion Criteria

The following inclusion criteria were used in selecting relevant articles for the review:

- Articles researching the client's perception (adults over 18) or experience of non – immediate or intrapersonal therapist self-disclosure
- Qualitative research
- Unpublished research
- Analogue/naturalistic study design
- Books
- Literature Reviews
- Dissertations/Theses

Exclusion Criteria were as follows

- Articles exploring immediate / intrapersonal disclosures only
- Articles exploring TSD from non-client perspectives
- Quantitative Research (initial review)
- Mixed methods research (initial review)
- Participants under the age of 18

As the initial systematic searches resulted in a very small number of papers, quantitative and mixed methods papers were included in the hand searches to widen the available literature and gain a richer understanding of clients' perspectives of TSD.

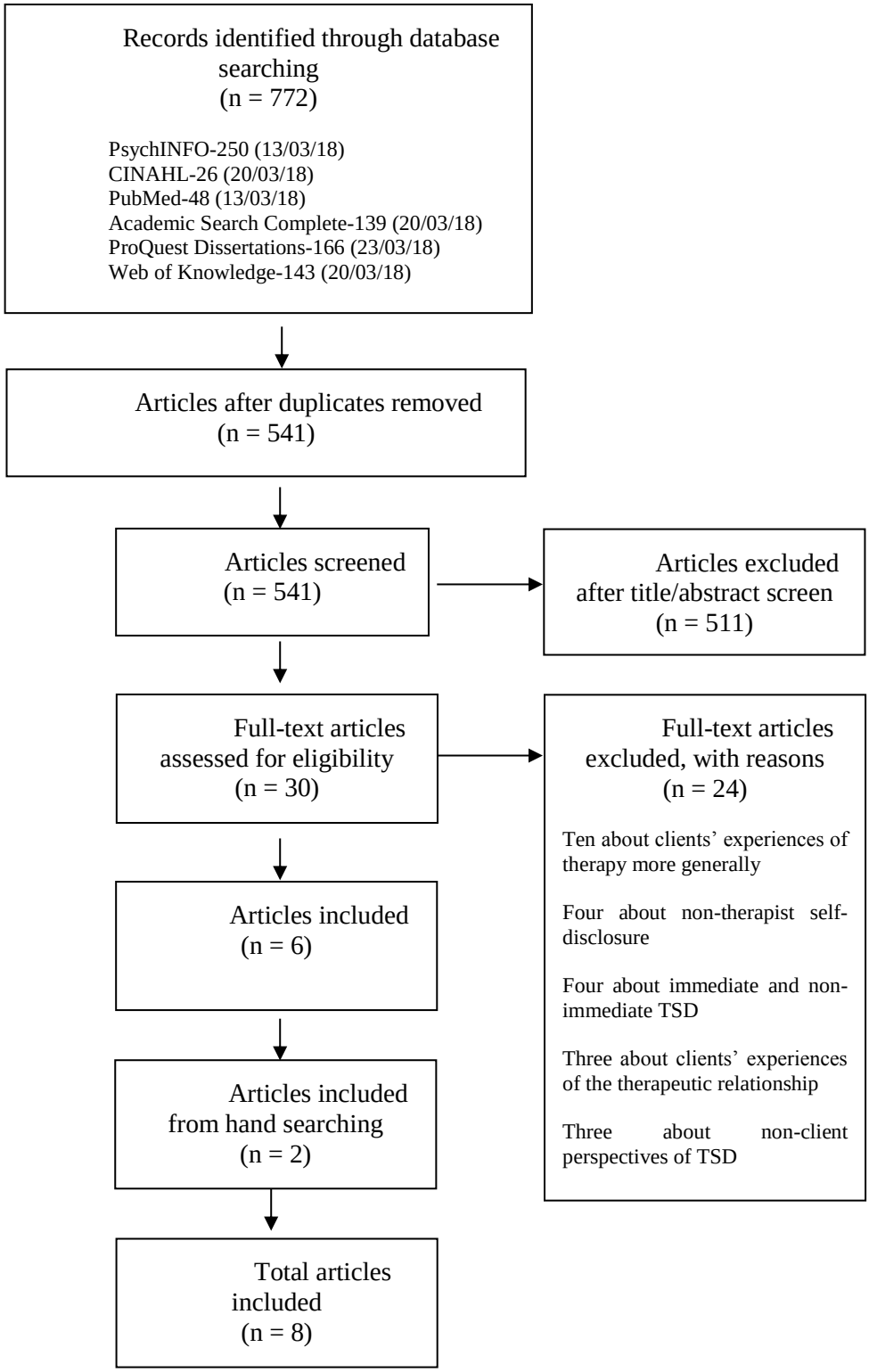

Figure 1. PRISMA flow diagram for the initial systematic searches carried out.

Analogue Studies - Published

Generally, analogue studies using case transcripts emerged during the 1970s and 1980s. These investigated the impact of TSD on therapist attributes such as likableness, warmth and professionalism (Hill et al, 1988) and found whilst greater use of TSD was associated with less favourable perceptions of the therapist's empathy, competence and trust (Curtis, 1982), a therapist disclosing having been in therapy was viewed as having more favourable therapeutic abilities than one who did not disclose (Fox, Strum & Walters, 1984). Similarly, other studies found students rated a disclosing therapist as more trustworthy and preferable than a non-disclosing therapist (Lundeen & Schuldt, 1989) and intrapersonal disclosures were associated with a warmer, more sensitive and honest therapist than a non-disclosing one (Nilsson, Strassberg & Bannon,1979). Conversely, minimally disclosing therapists using immediate disclosures were rated as more expert and professional than high disclosing therapists who shared personal information (McCarthy & Betz, 1978; McCarthy, 1979; Merluzzi, Banikiotes & Missbach, 1978).

Such discrepancy may be due to methodological differences such as sample size and gender, with some of the above studies using considerably larger samples, all female, or a mix of male and female participants. Likewise, whilst some used audio recordings of simulated counselling sessions, others such as Nilsson, Strassberg & Bannon, (1979) used video recordings, which undoubtedly provided more opportunity for participants to pick up on non-verbal body language of the therapist, which may explain why interpersonal disclosures were viewed particularly positively.

Later analogue research by Myers & Hayes (2006) found clients' perceptions of TSD were mediated by the strength of the therapeutic alliance. When rated as positive, non-immediate self-disclosing therapists were rated as more expert compared with immediate or

non-disclosing therapists. When rated as negative, clients rated therapists as less expert when using either type of disclosure. A recent study by Somers, Pomerantz, Meeks & Pawlow, (2014) found that undergraduates rated therapists who disclosed similar psychological difficulties to their clients in vignettes more favourably and more likely to develop a stronger therapeutic alliance and achieve therapeutic success with clients, than non-disclosing therapists.

Other analogue studies suggest that conceptualisations of roles in therapy may influence how clients experience TSD. Cherbosque (1987) for example, found that Mexican students rated a non-disclosing therapist as more trusting, worthy and expert than a self-disclosing one. This may be explained by Hispanic culture which values formalism and the social maintenance of roles (Constantine & Kwan, 2003).

The variation in research findings may be explained by methodological issues around sampling and ecological validity common to analogue studies. As clients in these studies were from a range of backgrounds, they may have had little in common with each other in terms of shared life experiences, therapy knowledge and/or experience. Furthermore, the timeframe between such studies may account for such discrepancy, given over the last two decades, there has been much more interest around TSD, reflected in the shift from the 'blank screen' perspective (Freud, 1912), towards a more contemporary understanding of TSD that places emphasis on a relational, rather than intrapsychic focus in therapy (Farber, 2006, Zur, 2007). Thus, as they are not methodologically robust, they provide limited insight into the experiences of actual therapy clients and offer little guidance to therapists considering self-disclosure (Hill & Knox, 2002).

Still, whilst the variability in analogue research on TSD can be attributed to the diverse methodological approaches used by studies and their corresponding limitations, the

only known meta-analytic study on the impact of TSD on clients (Henretty, Berman, Currier & Levitt, 2014) reviewed 53 (52 of which were analogue) studies and found that overall, disclosing therapists were viewed more favourably than non-disclosing therapists. TSD that conveyed similarity to the client and was of negative content variance (e.g. 'I have also had depression') had favourable impacts on clients compared with therapist nondisclosure, particularly concerning therapist professional attractiveness. Non-immediate disclosures about the therapist's personal life had a greater impact on therapist favourability than immediate disclosures, possibly due to greater prevalence in their use. Additionally, clients were more likely to return to therapy when disclosures indicated similarity with themselves.

Only two of the 53 studies used a clinical population and real therapy sessions, both of which had insignificant findings. Likewise, therapy setting (e.g. real, mock, transcript) was a significant moderator of clients' perceptions of TSD. This considerably limits the generalisability of findings and contests studies using real therapy clients who have found clients experience TSD positively, particularly when it conveys similarity to themselves (e.g. Barrett & Berman, 2001). There are likely to be fundamental differences between those who have experienced TSD in actual therapy, compared to those who have not, particularly when it comes to constructs of universality and empathy which are experiential processes through shared and 'felt sense' (Corcoran, 1981). Consequently, even studies which are considered to have good methodological vigour, tell us very little about actual therapy clients' experiences of TSD.

Real World Studies - Published

During the early nineties, studies looking at therapy clients' perceptions of TSD emerged. For example, Wells (1994) found that when exploring eight clients' experiences of immediate/interpersonal and non-immediate/intrapersonal TSD, four participants reported

TSD altered boundaries unfavourably, reducing the therapist's credibility and professionalism, whilst others felt it facilitated rapport and viewed the therapist as more trustworthy and understanding. Consistent with feminist perspectives on TSD (Mahalik, Van Ormer, & Simi, 2000), these participants reflected on the shift in power differentials, equating the therapeutic relationship to a friendship and 'equal' following TSD. Similar to analogue studies (e.g. Mayers & Hayes, 2006) the level of trust in the therapist prior to the disclosure affected the participant's ability to integrate positive implications of the disclosure into therapy, despite negative reactions. In three relationships where trust was tenuous, two participants withdrew from therapy shortly after disclosure, whereas those with a strong therapeutic alliance did not. This highlights the importance of the therapeutic relationship in determining clients' experiences of TSD.

Similarly, positive experiences of TSD were reported by Knox, Hess, Petersen & Hill (1997) who investigated the effects of (non-specified) TSD on thirteen clients in therapy. They found helpful TSD consisted of personal, non-immediate information about the therapist, which helped clients feel reassured and normalised their experiences. Clients viewed disclosing therapists as more real, human and felt disclosures facilitated equality. Although consistent with Cognitive Behavioural views on TSD, with clients describing new insights and effective problem-solving skills by internalising attributes of their therapists, the normalisation of their own experiences with a strengthening of the therapeutic alliance may have naturally biased clients to internalise the attributes of their therapists. This would suggest the beneficial functions of TSD are intertwined and are primarily derived from the initial impact of any disclosures on the therapeutic alliance.

Likewise, quantitative studies have also found that clients view TSD (and their therapist) more positively when a disclosure conveys similarity to themselves and is a

response to what they have shared with their therapist, although negative consequences of TSD being associated with blurring therapeutic boundaries through focusing on the therapists needs and thus, removing the focus from clients (Barrett & Berman, 2001). This supports humanist principles in suggesting TSD generates feelings of universality in clients through conveyance of therapist fallibility (Hill, Knox & Pinto-Coelho, 2019). As participants in Barrett & Berman's study were similar in age to therapists, this may have influenced their sense of similarity to the therapist to begin with and mediated the relationship between TSD and clients' views of their therapist. Whilst this is consistent with Wells (1994) in suggesting the therapeutic alliance prior to disclosure is important in determining the client's experience of it, it also indicates that therapist-client characteristics may be influential in clients' experiences of TSD.

Furthermore, unlike Wells' participants, those in this study were in therapy and were selected to participate by the therapists themselves, which may have resulted in selection bias by therapists asking only certain clients (e.g., those whom they knew had favourable experiences of TSD). Additionally, the instruction of therapists' disclosures may have been fundamentally different to disclosures made through choice. Given that the therapeutic alliance develops over time (Ardito & Rabellino, 2011) and as identified by Wells is likely to impact clients' experience of TSD, duration of therapy may have also affected clients' experience of TSD.

Similar findings are offered by Hanson (2005), who using a mixed methods study, asked sixteen women and two men currently in therapy about their experiences of TSD (and non-disclosure). Clients were two and a half times more likely to find TSD as helpful, and twice as likely to find non-disclosure as unhelpful. No differences were found between the helpfulness of non-immediate and immediate disclosure statements. Clients experienced TSD

as helpful because it contributed towards a real relationship characterised by feeling connected to, and understood by their therapist, a sense of trust and feeling less alienated.

Unhelpful disclosures were associated with therapist skill deficits in their delivery, leaving clients feeling unsafe, less trusting and needing to manage the relationship. Consistent with other studies (e.g. Wells, 1994) a positive pre-existing alliance mitigated against therapist skill deficits. Ten incidents of non-disclosure were experienced as helpful; clients reported they were free to imagine what their therapist was thinking, providing support for psychoanalytic arguments around facilitation of transference through non-disclosure (Rothstein, 1997). Unhelpful non-disclosure was associated with a lack of connection and trust, as well as inhibiting client self-disclosure, supporting Audet & Everall's (2010) finding that TSD facilitated client self-disclosure.

The emphasis on the *delivery*, as opposed to *type* of disclosure, offered by Hanson (2005) therefore, suggests that therapists' own skills and confidence in TSD is important in determining how a client will experience it. This was supported by the research of Cristelle Audet and colleagues who have published much of the qualitative literature using real therapy clients. When interviewing four clients about their experiences of counsellor self-disclosure (e.g. Audet & Everall, 2003), they found both hindering and beneficial effects, depending on how the disclosure was delivered and the client's expectations of therapy. Additionally, similar to Wells, intrapersonal disclosures positively affected the therapeutic alliance when trust and the therapeutic relationship had been established, but resulted in negative perceptions of the counsellor when they had not. Again, disclosure incongruence negatively affected the therapeutic alliance whilst clients felt that frequent disclosures deprived them of therapy time and interfered with the therapeutic process.

In a later study, Audet & Everall (2010) used Interpretive Phemenological Analysis (IPA) (Smith, 1996) to interview nine therapy clients about their experiences of non-immediate, intrapersonal TSD. Similar to earlier studies, TSD was associated with reducing power imbalances and increasing rapport. Clients were particularly attentive to the context of disclosures and if perceived as appropriate, the therapist was experienced as attentive and understanding. If considered too incongruent with their own experiences, clients viewed therapists as less responsive and understanding. Three participants described uncertainty around TSD leading to role confusion, and in some cases reversal, whereby clients had to navigate themselves between both client and therapist. Additionally, consistent with Jourard (1971) in proposing that self-disclosure facilitates disclosure in the other within a dyad, clients described feeling they could share information they would not have if their therapist did not self-disclose.

It may be that upon hearing their therapists self-disclose, clients felt empowered to share more of themselves due to reduced power differentials. If so, this suggests that TSD may be a particularly useful way to engage clients, especially those that may be fearful or withdrawn. Support for this was found in further analysis of their original (2010) data, (e.g. Audet & Everall, 2011) when exploring TSD in the context of boundaries, with clients reporting that it reduced power imbalances, humanised therapeutic interactions and made them feel less objectified and more functional. They viewed therapist fallibility, communicated through TSD, as complementary to the therapeutic relationship. Clients' willingness to share more of themselves is also consistent with theoretical ideas that suggest TSD is helpful to model behaviours and ways of being that are healthy for the client (Goldfried, Burckell & Eubanks-Carter, 2003). Therapist self-disclosure that revealed 'significant inadequacies' in the therapist's life, however, did reduce their credibility and competence, whilst sharing of personal successes enhanced this in the eyes of their clients.

Similar to earlier studies (Barrett & Berman, 2001; Wells, 1994) negative effects of TSD were associated with confusion over therapeutic boundaries, to role reversal.

This highlights the importance of disclosure congruence, reflecting the findings of Barrett & Berman (2001) in suggesting that clients experience TSD more positively when it conveys similarity to themselves. The sense of role confusion and reversal referred to, however, raises questions around TSD and power within the therapeutic relationship. Although intended to create equilibrium, TSD may position the therapist as vulnerable, forcing the client to reciprocate a rescuing role. As evidenced by Knox et al, (1997) and Wells (1994), blurring of therapeutic boundaries seems to be a consistent experience for clients experiencing TSD, although this is likely to be dependent on how the disclosure is delivered, as evidenced by Hanson (2005). TSD that reveals 'significant inadequacies' is important, as it places emphasis on the *type* of disclosure and accentuates the importance of heterogeneity in personal information disclosed by therapists. What constitutes as significant inadequacies, however, is ambiguous, and humanising disclosures that increase therapist fallibility may well place the therapist's credibility at greater risk of being jeopardised.

Whilst asking clients directly about their experiences of TSD is preferable, the impact of TSD on therapy outcome is a less direct way of gaining feedback and offers greater flexibility around data collection through utilisation of routine outcome measures, for example. An example of this is provided by Ziv-Beiman, Keinan, Livneh, Malone & Shahar (2017), who in the first randomised control trial on TSD, examined the effect of immediate and non-immediate TSD with 86 clients receiving twelve sessions of integrative psychotherapy. Compared with non-immediate TSD or no TSD, immediate TSD increased a favourable perception of the therapist from client ratings and reduced psychiatric symptoms post-treatment. Similar results are provided by Levitt et al (2016) who found TSD reduced

symptom distress and interpersonal difficulties post intervention, although non-immediate, humanising disclosures and those which conveyed similarity to the client also had the same effect.

Supporting Barrett & Berman's (2001) finding, clients may rate therapists more favourably when using immediate disclosures because they feel the disclosure is more relevant to them, as it relates directly to something they have shared with the therapist. This highlights the importance of disclosure congruence, as evidenced by other studies (e.g. Audet & Everall, 2010). The need to feel understood by mental health professionals more generally appears to be a common experience for clients (e.g. Shatell, Starr & Thomas, 2007) and this suggests that TSD could be considered to fall under the 'non-specific' treatment effects in therapy (Chatoor, & Kurpnick, 2001) through therapist validation, attunement and empathy, which the client may experience through either immediate or non-immediate disclosures.

The finding that non-immediate TSD did not affect clients' perceptions of their therapists provided by Ziv-Beiman et al (2017) contests the much-supported view that TSD is helpful because it humanises the therapist and increases feelings of universality in clients (e.g. Knox, et al, 1997; Levitt, Butler & Hill, 2006). However, in Ziv-Beiman et al's study, therapists in the non-immediate disclosure condition were instructed whether to disclose and what. Left uninstructed, it is possible they may have disclosed something significantly more personal that increased their fallibility, which would account for why non-immediate disclosures did not significantly affect client perceptions of favourability. This may explain the contradiction in research findings and signify that the *type* of personal information the therapist reveals is important in the client's experience of it, as supported by Audet & Everall (2010).

Whilst studies investigating TSD have generally used Caucasian or European American samples (Constantine & Kwan, 2003), the meaning of TSD is likely to be culturally bound (Cashwell, Shcherbakova & Cashwell, 2003), so this limits their generalisability to non-Caucasian cultures. African American clients, for example, may be more likely to make race-related disclosures to racially dissimilar therapists who self-disclose (Helms & Cook, 1999). In cross-racial and cross-cultural dyads, clients may require their therapists to demonstrate awareness and sensitivity in dealing with racial matters (Sue & Sue, 2003), which may encourage the therapist to self-disclose information they may not have otherwise.

Cross-cultural differences in a client's understanding of therapy and the therapist's role may call for TSD around therapists' professional background and qualifications (Lee, 1997). Cultural differences and stigma around help seeking for psychological distress may mean therapists need to incorporate increased use of self-disclosure to model helpful therapeutic tools and develop a therapeutic alliance (Constantine & Kwan, 2003). Black and other non-white ethnic minorities may be fearful of white mental health professionals and had negative, culturally insensitive experiences of Westernised healthcare. This may have prevented them from accessing formal mental health treatment (Bhui et al, 2003; Constantine, 2002, Sainsbury Centre for Mental Health, 2006), particularly in the UK where black and minority ethnicity (BAME) populations have received poor services and health outcomes (Department of Health, 2008).

Although client perspectives of TSD with culturally or racially diverse participants are rare, Constantine and Kwan (2003) provide a case illustration describing a black female experiencing racial and sexual discrimination at work asking her white therapist about her experiences of workplace discrimination. Whilst the therapist did not self-disclose initially

and validated her client's experience, the client felt frustrated and doubted whether she could trust the therapist because she wanted to know whether she understood her experiences. After she shared her feelings with the therapist who apologised and explained she did not want her response to deter from the client's experience, she disclosed her own experiences of workplace discrimination. The therapist continued to use self-disclosure following the client's questions around being a professionally successful woman, strengthening the therapeutic relationship and therapeutic progress. Here, TSD was especially important for the client given that she was more likely to experience oppression based on the intersecting of her ethnicity and gender (Cole, 2009, Crenshaw, 1989) compared with gender alone, and therefore needed to know her therapist understood this.

This is consistent with the suggestions made by Sue & Sue (2003) around clients in cross-racial therapeutic dyads requiring their therapists to demonstrate cultural sensitivity and awareness, which may involve a greater degree of TSD. Not disclosing may lead to further marginalisation and therapeutic impasse (Wachtel, 1993) in the client's attempts to protect themselves from further harm by an emotionally distant therapist (Goldstein, 1994). Gender may have strengthened the therapeutic alliance; although not black, the therapist shared some similar attributes with her client as a professional, career-oriented woman, supported by literature pertaining to clients experiencing TSD positively when it conveys similarity to the client (Barnett & Berman, 2001).

Bitar, Kimball, Bermúdez & Drew (2014) used IPA to explore ten Mexican-America court mandated mens' experiences of non-immediate intrapersonal self-disclosure from Anglo-American therapists. Consistent with previous research using predominantly Caucasian participants, all ten participants reported that TSD had made it easier for them to self-disclose, strengthened the therapeutic alliance and reduced power differentials,

humanised the therapist, normalised the clients' experiences and modelled self-disclosing behaviours.

These findings are consistent with multicultural models that place emphasis on therapist authenticity (Vasquez, 2009), and suggest that clients in cross-racial therapy dyads and particularly marginalised populations may have different views of TSD resulting from experiences of oppression (Sue & Sue, 1999). This is in keeping with culturally sensitive approaches to therapy which engender mutual empowerment and collaboration (Sparks, 2009), and supports feminist perspectives and approaches to TSD (Roberts, 2005). Therapists should therefore consider disclosure decisions within the context of culturally competent practice, akin to the socio-political experiences of their clients characterised by the interlinking of one's personal experiences with external political influences leading to oppression.

Another client group receiving attention regarding the need for connection and identification with their therapist through TSD is the lesbian, gay, bisexual, transgender, queer and intersex (LGBT+) population (Kronner & Northcut, 2015). Socialisation experiences have often led such individuals to conceal part of their identity (Hatzenbueler, McLaughlin, Keyes & Hasin, 2010), calling for a greater need for therapist empathy through the sharing of therapists' own experiences of oppression and marginalisation, viewed as an essential part of the therapeutic process (Coolhart, 2005, Knox & Hill, 2003). Likewise, LGBT+ individuals may wish to see a LGBT+ therapist to reduce the chances of homophobia (Cabaj & Stein, 1996).

Unsurprisingly, client perspectives around TSD with this population remain sparse, although in a qualitative study by Kronner & Northcut (2015) exploring gay male therapist-client dyads experiences of TSD, clients were highly attentive to TSD, whether implicit

(including immediate/interpersonal) or explicit (including non-immediate/intrapersonal), although implicit disclosures were far more common (used 80 per cent of the time). Clients experienced both implicit and explicit disclosures as beneficial to the therapeutic process. They perceived explicit relational disclosures that revealed something about the therapist's personal life as particularly helpful in normalising their experiences and modelling feelings.

Interestingly, therapists also reciprocated this view, which contests other research indicating discrepancies between clients' and therapists' views of TSD (e.g. Edwards & Murdock, 1994). This may in part be due to the therapist's own bias in selecting clients that held similar views to themselves and had positive experiences of therapy, reflecting the apparent lack of negative experiences and views of TSD expressed by clients. Furthermore, both clients and therapists were inherently similar in their sexuality, which would have both strengthened the therapeutic rapport and increased the chances of TSD being congruent with the clients' experiences.

Another group of individuals that may have different needs around TSD based on their cultural experiences of power is military veterans (Boman, 1985; Brooks, 2001). Despite much development in therapeutic services for veterans, their voices remain unheard in the academic literature (Stack, 2013). In exploring ten British ex-military clients' experiences of psychological therapy, Stack (2013) found that whilst withholding of information by the therapist left clients feeling disempowered, TSD facilitated engagement. Likewise, clients valued a relational approach whereby they experienced the *person* of the therapist in a two-way conversation, demonstrating the importance of TSD as a facilitator for empowerment and equality, as endorsed by feminist perspectives (e.g. Mahalik, Van Ormer, & Simi, 2000).

As Stack notes, military clients may have experienced their seniors withhold information from them in potentially disempowering ways, so TSD in this context, serves to mitigate against unhelpful enactments of previous experiences of oppression. Stack's participants also reflected on the importance of therapeutic boundaries given the structure of military life. Although they did not allude to TSD specifically, this may further highlight the need for therapists to consider their client's assumptions around professional roles and structure in therapy based on their individual or cultural experiences when making disclosure decisions (Constantine & Kwan, 2003).

Another example of clients who may have specific needs around TSD are those who have experienced specific types of trauma. A case illustration by Rao (2015) explores the author's own experiences of dual roles as provider and hurricane trauma victim involving the use of TSD with a client who was also the victim of the hurricane. TSD helped the client to feel less isolated, respected and treated equally, which facilitated engagement in treatment and both his own and the therapist's healing. Like with the BME and sexuality literature, the specific experiences of some clients as highlighted here may lead to greater feelings of isolation, calling for TSD to be utilised as a tool to facilitate feelings of universality in clients. In such instances, intrapersonal, non-immediate TSD that reveals something about the therapist's personal life that is congruent with the client's own experiences can be experienced as beneficial.

Real World Studies - Unpublished

Similar to the published empirical literature, the unpublished research on clients' experiences of TSD is scarce and generally consists of counselling psychology doctoral theses and undergraduate dissertations shared online via the ProQuest Dissertation and Theses database. Nussbaum (2014) for example, conducted a phenomenological study of

eight clients and found that whilst non-verbal disclosures (therapist facial expression, attire, age etc.) were perceived as more meaningful than verbal disclosures, disclosing personal information accounted for 72 percent of all verbal disclosures compared with 28 percent of professional (e.g. qualifications, attendance at conferences) discourses. Disclosure of professional behaviour, either verbal (communicating qualifications, knowledge of research or other professional activities) or non-verbal (punctuality, boundary setting, non-judgmental) was experienced as particularly meaningful. Clients liked knowing that their therapist stayed current with research and attended conferences. They also appreciated a therapist who dressed 'professional' and 'stylish', as well as how they managed themselves in sessions, emphasising the importance of non-verbal TSD in terms of therapist's appearance and demeanour.

Overall, clients' negative and positive experiences of TSD were consistent. Clients had varying experiences of TSD even for similar disclosures, influenced by a number of factors including their beliefs, values, life experiences and personality. Positive experiences were associated with personal disclosures that strengthened the therapeutic alliance and normalised not only the clients' experiences, but also enabled them to view the therapist as someone who was both successful and ordinary, facilitating hope for themselves. Disclosures that were unintentional and out of the therapist's control were related with negative experiences for clients.

A unique characteristic of this study is the integration of non-verbal TSD, often neglected in the literature on clients' perspectives. Perhaps there is an assumption that this is less meaningful, yet these findings suggest otherwise and would indicate therapists should reflect on what they may unintentionally or non-verbally disclose to clients, and how this might impact them, as well as what they choose to communicate verbally.

Zucker (2014) explored how eight men and three women who regularly attended Alcoholics Anonymous experienced non-immediate, intrapersonal TSD in individual therapy. Using a Grounded Theory Approach (Glaser & Strauss, 1967) they found seven major themes; clients valued appropriately timed, general and relevant TSD when used to demonstrate empathy, concern and that the therapist had faced similar challenges. Negative aspects of TSD were associated with disconnect between the therapist and themselves, and too much and/or irrelevant TSD, again highlighting the importance of disclosure congruence. Four participants reported that sharing of the therapist's ongoing challenges was not helpful, suggesting that resolution of the therapist's difficulties may affect how clients perceive them.

It may be that TSD of current or unresolved difficulties may alter boundaries unfavourably and force the client into a caretaking role (Meiselam, 1990; Wachtel, 1993). This parallels quantitative research which has found that immediate (countertransference) disclosures that were more resolved led participants to view the therapist as more trustworthy, attractive and inspiring of hope, compared to disclosures that were less resolved (Yeh & Hayes 2011). Additionally, the high proportion of male participants may have influenced their experience of TSD, given that historically, there has been less of an emphasis for boys and men to be socialised to focus on the needs of others (Larkin & Popaleni, 1994), and so eliciting feelings of needing to care for the therapist may have been significantly more uncomfortable for them. Whilst collectively, a quantitative review by Henry, Currier, Berman & Levitt (2010) failed to find any clear relationship between client/therapist gender and TSD, individual studies have found gender differences in clients' preferences around TSD (Hendrick, 1988; Watkins & Schneider, 1989) and as highlighted earlier (e.g. Barnett & Berman 1991), other therapist-client characteristics such as age may indirectly influence how disclosures are experienced by clients. This suggests that when considering disclosure

decisions, therapists should be considerate of demographic characteristics that may influence their client's experience of potential disclosures

Again, an earlier study by Rabassa (2009) using IPA to explore nine (four male and five female) clients' experiences of immediate and non-immediate TSD within a UK CBT service, found clients' experiences to be consistent with those reported by other studies, in terms of normalising clients' emotions, modelling helpful cognitions and helping to build trust through a shared similarity between client and therapist. Their experiences of TSD, however, were not consistent over time and dependant on their mood states and personal characteristics. Unhelpful experiences of TSD, either withheld or delivered, were associated with disempowerment of either client or therapist. Interestingly, non-disclosure by the therapist upheld assumptions of the therapist as a skilled and trustworthy professional, whilst retaining the focus on themselves.

As highlighted in other studies (e.g. Audet & Everall, 2010) evidence suggests there is a greater risk of professional credibility being jeopardised though TSD, depending on what is disclosed and how, and so therapists should reflect on their own competence and feelings around disclosing, particularly highly personal information. Furthermore, whilst congruence is consistently highlighted as important in clients' experiences of TSD, perhaps in this sense, it has a different meaning related to the therapist sharing information that will be helpful for the client to know based on their presentation at that time, and their unique characteristics, as opposed to it being congruent to their overall difficulties.

As other studies using White participants demonstrate, there are likely to be differences in the experiences of real therapy clients compared with both non-therapy and student populations. An unpublished study by Patel (2006), interviewed six (five female, one male) South Asian therapy clients about their experiences of non-immediate, intrapersonal

TSD. All but one of the therapists referred to identified as White-British. Participants reported positive experiences of TSD, feeling that it helped to strengthen the therapeutic alliance, reduce power imbalance and build trust and therapist credibility and authenticity. Two of the participants experienced TSD negatively; they described feeling it was irrelevant to their experiences, highlighting the importance of disclosure congruence as indicated by other, none ethnically diverse studies (Audet et al, 2010; Barret & Berman, 2001). Despite this, these participants remained in therapy, were able to resolve this experience and maximise the therapeutic benefits. This is similar to Wells' (1994) participants who integrated positive aspects of TSD into therapy despite negative reactions when the therapeutic alliance and trust was strong, yet when tenuous terminated therapy.

An unpublished quantitative study by Bashan (2004) exploring clients' preferences around TSD of sexual orientation, found a greater preference for therapists disclosing their sexual orientation, particularly early on in treatment because it helped to form a safe and trusting environment. Whilst increasing trust has been shown as an important feature of TSD in non-sexuality related studies (Peschken & Johnson, 1997) it is likely to have greater significance given the discrimination that many LGBT individuals still face today (Government Equalities Office, 2018). As with ethnicity, this suggests that LGBT individuals may have specific experiences around TSD.

Analogue Studies - Unpublished

As suggested earlier, the *type* of personal information disclosed by therapists is likely to considerably influence clients' experiences, particularly around professional credibility. Whilst there is a paucity of disclosure specific studies, Kaufman (2016) in the only known mental health related TSD study, explored perceptions of TSD of a mental health condition using case vignettes with 267 undergraduates. Whilst participants rated therapists who

disclosed a mental health condition (attention deficit disorder, depression, and anxiety) as significantly more attractive and empathic than therapists who did not, the type of mental health condition did not affect ratings. Similarly, McCormic (2017) found that using case vignettes, psychology undergraduates perceived therapists who disclosed a mental health difficultly similar to the clients, more positively than therapists who disclosed nothing. Unlike studies using real therapy clients (e.g. Zucker, 2014) disclosure extent (i.e. mild vs moderate/extensive) did not affect perceptions.

Given the stigma attached to mental health (Sickel, Seacat, & Nabors, 2019), disclosure of a mental health condition may come with added risk for therapists, particularly so in the context of Audet & Everall's (2010) findings which suggest disclosures revealing 'significant inadequacies' in the therapist's life may jeopardise professional integrity. Whilst the findings of Kaufman and McCormic refute this, the ecological validity of the undergraduate samples used in both studies is poor compared to the Audet & Everall's participants who had experienced TSD in the context of actual therapy. In fact, 44 per cent of McCormic's participants said they did not relate to the vignettes, possibly explained by them being undergraduates as apposed to actual therapy clients. This emphasises the importance of using participants who have been in therapy, as fundamentally, their experiences and views around TSD are likely to be different.

Conclusion

Sharing personal information with clients during therapy can be helpful when certain factors are considered, such as the disclosure congruence with the client's own experiences and the timing and frequency of disclosures. Therapists should be cautious of using disclosures that reveal something about their personal life, beliefs or values when the therapeutic alliance is new. Lack of familiarity with the therapist in such instances may leave

clients feeling uncontained and confused over therapeutic boundaries. It also increases the risk of the therapeutic relationship becoming fractured and harder to repair, should the client find the disclosure difficult.

Therapy clients are heterogeneous with their own characteristics and needs. Evidence suggests that there may be particular cultural, racial or other identity experiences that mean sharing of therapists' own experiences of these issues is fundamental to forming a strong therapeutic alliance and helping the client to feel less alone. This is particularly so for those from marginalised backgrounds and those who have experiences of oppression. Therapists should therefore consider the wider concept of cultural competence when making non-immediate disclosure decisions, their reasons for the disclosure and what this may mean for the client in terms of their cultural and social heritage.

Additionally, some evidence indicates that clients may vary in their need for TSD as they go through therapy and depending on their presentation at the time. The inherent vulnerability of being in therapy means therapists should demonstrate sensitivity and flexibility to their client's emotional states, including potential decisions of what, how and when to disclose. This means any disclosures should be shared in a manner which encourages therapeutic development at an appropriate pace. In this sense, for TSD to be used effectively, the concept of the client's Zone of Proximal Development (ZPD) (Vygotsky, 1978), may be a helpful framework. The ZPD may be usefully understood as the distance between an individual's current position, to the next stage of development, moving through phases in a stepwise manner, to reach one's fullest potential. In the psychotherapy field, the therapist works within the client's therapeutic ZPD, providing a sense of safety between their existing level and the next stage of personal growth and narrative progression (Stiles, Caro Gabalda, & Ribeiro, 2016). TSD therefore, presents an opportunity to helpfully challenge the client's

self-narrative if done carefully, sensitively, and in a manner which is well-paced. Additionally, this may even call for therapists to move outside of their own comfort zones around TSD to meet the needs of the client and establish a greater degree of intimacy within the therapeutic relationship. As such, the importance of clinical supervision is imperative in determining that potential disclosures will be made to fully meet the client's needs at the time.

Future Research

Therapist self-disclosure is a vast area, and although this review has identified some guidance for therapists based on existing research, the methodological rigour of existing research is limited, mainly due to the lack of published studies including people who have accessed therapy, and experienced TSD. Perspectives, however, have changed significantly over time, with less of an emphasis on the 'blank screen' approach and a move towards a more reciprocal relationship between client and therapist to engender mutual empowerment. This may explain why early studies have been predominately analogue in nature, whereas the move towards acceptability of TSD has provided gateway for the experiences of real therapy clients to be explored.

Nevertheless, such studies tend to use definitions of TSD rather loosely, leaving a poor understanding of various types, their function and effect on clients in therapy. Although they may discriminate between disclosures which are a response to an 'in session' event and those which reveal something about the therapist's personal life, the latter becomes more ambiguous considering a) what is personal to one therapist may not be to another b) the extent and/or nature of personal information shared is often unexplored, with 'personal' being used as a generic term. Thus, the range of potential personal disclosures is extensive and clients' experiences will be dependent on just how much of the *personal*, is shared. Sharing

more of one's self as a therapist may come with greater ambiguity and risk to the client, yet currently, there is little on the experiences of clients who have borne witness to the most intimate disclosures from their therapists. Whilst the existing literature shows that disclosures congruent to clients' own experiences are viewed as helpful, how does this translate to therapists who may consider disclosing personal information related to why the client is in therapy themselves i.e. the therapist's own experience of psychological distress and/or a mental health difficulty? The current literature is limited in what it can offer for this unexplored territory. Future research, therefore, should focus on the experiences of clients who have experienced such disclosures.

References

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, *38*, (2), 171.

Andersen, B., & Anderson, W. (1989). Counselors' reports of their use of self- disclosure with clients. *Journal of Clinical Psychology*, *45*, (2), 302-308.

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*, 270.

Audet, C., & Everall, R. D. (2003). Counsellor self-disclosure: Client-informed implications for practice. *Counselling and Psychotherapy Research*, *3*, (3), 223-231.

Audet, C.T, & Everall, R.D. (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective. *British Journal of Guidance & Counselling*, *38*, (3), 327-342.

Audet, C. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24*, (2), 85-100.

Barnett, J.E. (1998). Should psychotherapists self-disclose? Clinical and ethical considerations. In Vandecreek L, Knapp, S and Jackson TL (eds) *Innovations in Clinical Practice: A Source Book*. Sarasota, FL: Professional Resource Exchange.

Barrett, M.S., & Berman, J.S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, *69*, (4), 597-603.

Bashan, F. (2004). *Therapist self-disclosure of their sexual orientation: From a client's perspective* (Doctoral dissertation, Wright Institute Graduate School of Psychology).

Baumeister, R. F., & Leary, M. R. (1997). Writing narrative literature reviews. *Review of General Psychology*, *1*, (3), 311.

Bedi, R. P. (2006). Concept mapping the client's perspective on counseling alliance formation. *Journal of Counseling Psychology*, *53*, (1), 26.

Bedi, R. P., Davis, M. D., & Williams, M. (2005). Critical Incidents in the Formation of the Therapeutic Alliance from the Client's Perspective. *Psychotherapy: Theory, Research, Practice, Training*, *42*, (3), 311.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Therapist variables in psychotherapy process and outcome. *Handbook of Psychotherapy and Behavior Change*, *3*, 257-310.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. *The British Journal of Psychiatry*, *182*, (2), 105-116.

Bitar, G. W., Kimball, T., Bermúdez, J. M., & Drew, C. (2014). Therapist self-disclosure and culturally competent care with Mexican–American court mandated clients: A phenomenological study. *Contemporary Family Therapy*, *36* (3), 417-425.

Bloomgarden, A, & Mennuti, R. B. (2009). Therapist self-disclosure: Beyond the taboo. In A. Bloomgarden and R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 3-15). New York, NY: Routledge.

Boman, B. (1985). Psychotherapy with Australian Vietnam veterans. *Journal of Australian Social Work*, *38*, (3), 19-25.

Breckbill, Anne L. (2014). *The Impact of Personal Therapy on Therapists' Use of Self-Disclosure*. Retrieved from https://sophia.stkate.edu/msw_papers/294/.

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy: Theory, Research, Practice, Training, 38,* (1), 21.

Brooks, G. (2001). Counseling and psychotherapy for male military members. In G.R. Brooks & G.E. Good (Eds.), *The new handbook of counselling and psychotherapy with men* (pp.206–226). San Francisco: Jossey-Bass.

Brown, L. S. (1994). *Subversive dialogues: Theory in feminist therapy*. New York, NY, US: Basic Books.

Brown, L. S., & Walker, L. (1990). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp.13-154). New York, NY: Plenum Press.

Cabaj, R. P., & Stein, T. S. (Eds.). (1996). *Textbook of homosexuality and mental health*. Arlington, VA, US: American Psychiatric Association.

Carew, L. (2009). Does theoretical background influence therapists' attitudes to therapist self-disclosure? A qualitative study. *Counselling and Psychotherapy Research, 9,* (4), 266-272.

Cashwell, C.S., Shcherbakova, J., & Cashwell, T.H. (2003). Effect of client and counsellor ethnicity on preference for counselor disclosure. *Journal of Counseling & Development, 81,* (2), 196-201.

Castonguay, L.G., Constantino, M.J., & Grosse Holteforth, M. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, Research, Practice Training, 43*, (3), 271-279.

Chatoor, I., & Kurpnick, J. (2001). The role of non-specific factors in treatment outcome of psychotherapy studies. *European Child & Adolescent Psychiatry*, *10*, (1), S19.

Chelune, G. J. (1979). *Self-disclosure: Origins, patterns, and implications of openness in interpersonal relationships.* San Francisco: Jossey-Bass.

Cherbosque, J. (1987). Differential effects of counselor self-disclosure statements on perception of the counselor and willingness to disclose: A cross-cultural study. *Psychotherapy: Theory, Research, Practice, Training*, *24*, (3), 434.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*, (3), 170.

Constantine, M. G. (2002). Predictors of satisfaction with counseling: Racial and ethnic minority clients' attitudes toward counseling and ratings of their counselors' general and multicultural counseling competence. *Journal of Counseling Psychology*, *49*, (2), 255.

Constantine, M.G., & Kwan, K.L.K. (2003). Cross-cultural considerations of therapist self-disclosure. *Journal of Clinical Psychology, 59*, (5), 581-588.

Coolhart, D. (2005). Out of the Closet and into the Therapy Room: Therapist Self-Disclosure of Sexual Identity. *Guidance & Counselling*, *21*, (1), 3-13.

Corcoran, K. J. (1981). Experiential empathy: A theory of a felt-level experience. *Journal of Humanistic Psychology*, *21*, (1), 29-38.

Crenshaw, K. (2018). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics [1989]. In *Feminist Legal Theory* (pp. 57-80). Routledge.

Curtis, J. M. (1981). Indications and contraindications in the use of therapist's self-disclosure. *Psychological Reports, 49,* (2), 499-507.

Curtis, J. M. (1982). The effect of therapist self-disclosure on patients' perceptions of empathy, competence, and trust in an analogue psychotherapeutic interaction. *Psychotherapy: Theory, Research, and Practice, 19,* (1), 54-62.

Department of Health (2008). *Reports on self-reported experiences of patients from black and minority ethnic groups.* London: Department of Health.

Domenici, T. (2006). Reflections on infecting the treatment. *Journal of Gay & Lesbian Psychotherapy, 10,* (1), 39-56.

Edwards, C.E & Murdock, N.L (1994). Characteristics of therapist self-disclosure in the counseling process. *Journal of Counseling and Development, 72,* (4), 384-389.

Farber, B. A. (2006). *Self-disclosure in psychotherapy*. New York, NY, US: Guilford Press.

Farber, B.A. (2003). Patient self-disclosure: A review of the research. *Journal of Clinical Psychology/In Session, 59,* (5), 589-600.

Fox, S. G., Strum, C. A., & Walters, H. A. (1984). Perceptions of therapist disclosure of previous experience as a client. *Journal of Clinical Psychology, 40,* (2), 496-498.

Freud, S. (1912). The dynamics of transference, standard edition, Vol. 12. *Freud, S. (1912b), Recommendations to physicians practicing psychoanalysis. Standard Edition, 12,* 11-120.

Freud, S. (1958a). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 97-108). London, England: Hogarth Press. (Original work published 1912).

Freud, S. (1958b). Recommendations to physicians practicing psychoanalysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 109-120). London, England: Hogarth Press. (Original work published 1912).

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology*, *41*, (3), 296.

Glasby, J., & Lester, H. (2005). On the inside: a narrative review of mental health inpatient services. *British Journal of Social Work*, *35*, (6), 863-879.

Glaser, B., & Strauss, A. (1967). The discovery of grounded theory. *London: Weidenfeld and Nicholson*, *24*, (25), 288-304.

Goldfried, M. R., Burckell, L. A., & Eubanks-Carter, C. (2003). Therapist self-disclosure in cognitive behavior therapy. *Journal of Clinical Psychology*, *59*, (5), 555-568.

Goldstein, E. G. (1994). Self-disclosure in treatment: What therapists do and don't talk about. *Clinical Social Work Journal*, *22*, (4), 417-433.

Government Equalities Office. (2018). *National LGBT Survey: Summary Report*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722314/GEO-LGBT-Survey-Report.pdf.

Goz, R. (1975). On knowing the therapist "as a person". *International Journal of Psychoanalytic Psychotherapy, 4*, 437-458.

Ham, C.C., LeMasson, K.D.S., & Hayes, J.A. (2013). The use of self – disclosure: Lived experiences of recovering substance abuse counsellors. *Alcoholism Treatment Quarterly, 31*, (3), 348-347.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and nondisclosure affects clients. *Counselling and Psychotherapy Research*, *5*, (2), 96-104.

Hatzenbuehler, M. L., McLaughlin, K. A., Keyes, K. M., & Hasin, D. S. (2010). The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations: A prospective study. *American Journal of Public Health*, *100*, (3), 452-459.

Hawkins, I. A., & Bullock, S. L. (1995). Informed consent and religious values: A neglected area of diversity. *Psychotherapy: Theory, Research, Practice, Training*, *32*, (2), 293.

Health & Care Professionals Council. (2016). *Standards of conduct, performance, and Ethics.* London: HCPC.

Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process*. Needham Heights, MA, US: Allyn & Bacon.

Hendrick, S. S. (1988). Counselor self-disclosure. *Journal of Counseling & Development*, *66*, (9), 419-424.

Hendrick, S.S (1990). A client perspective on counsellor disclosure. *Journal of Counseling and Development, 69*, (2),184-185.

Henretty, J. R., Currier, J. M., Berman, J. S., & Levitt, H. M. (2014). The impact of counselor self-disclosure on clients: A meta-analytic review of experimental and quasi-experimental research. *Journal of Counseling Psychology, 61*, (2), 191.

Henretty, J.R., & Levitt, H.M. (2010). The role of therapist self-disclosure in psychotherapy: A Qualitative Review. *Clinical Psychology Review, 30*, (1), 63-67.

Hill, C. E., & Knox, S. (2001). Self-disclosure. *Psychotherapy: Theory, Research, Practice, Training, 38*, (4), 413.

Hill, C. E., Helms, J. R, Tichenor, V., Spiegel, S. B., O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35*, (3), 222.

Hill, C. E., Knox, S., & Pinto-Coelho, K. G. (2019). Self-disclosure and immediacy. *Psychotherapy Relationships That Work: Evidence-Based Therapist Contributions*, *1*, 379.

Hill, C.E., & Knox, S. (2002). Self-disclosure. In J.C. Norcross (Ed.*), Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 255-265). New York: Oxford University Press.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, (2), 139-233.

Kahn, M. D. (1991). *A series of books in psychology. Between therapist and client: The new relationship.* New York, NY, US: W H Freeman/Times Books/ Henry Holt & Co.

Kaschak, E. (2016). Feminist psychotherapy. *The Wiley Blackwell Encyclopaedia of Gender and Sexuality Studies*, 1-5.

Kaufman, S. (2016). *The effects of therapist self-disclosure of a mental health condition on client perceptions of the therapist*. (Unpublished doctoral dissertation). Philadelphia College of Osteopathic Medicine, Philadelphia, PA.

Knox, S., & Hill, C.E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology/In Session, 59,* (5), 529-539.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, *44*, (3), 274.

Kronner, H. W., & Northcut, T. (2015). Listening to both sides of the therapeutic dyad: Self-disclosure of gay male therapists and reflections from their gay male clients. *Psychoanalytic Social Work*, *22*, (2), 162-181.

Larkin, J., & Popaleni, K. (1994). Heterosexual courtship violence and sexual harassment: The private and public control of young women. *Feminism & Psychology*, *4*, (2), 213-227.

Lee, E. (1997). Overview: The assessment and treatment of Asian American families. *Working with Asian Americans: A guide for clinicians*, 3-36.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly*, *29*, (1), 7-28.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology*, *53*, (3), 314.

Lundeen, E. J., & Schuldt, W. J. (1989). Effects of therapist's self-disclosure and a physical barrier on subjects' perceptions of the therapist: An analogue study. *Psychological Reports*, *64*, (3), 715-720.

Mahalik, J. R., van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Practicing feminist ethics in psychology* (pp. 189-201). Washington, DC: American Psychological Association.

Mathews, B. (1988). The role of therapist self-disclosure in psychotherapy: A survey of therapists. *American Journal of Psychotherapy, 42*, (4), 521-531.

Mathews, B. (1989). The use of therapist self-disclosure and its potential impact on the therapeutic process. *Journal of Human Behavior & Learning*, *6*, (2), 25-29.

McCarthy, P.R. (1979). Differential effects of self-disclosing versus self-involving counsellor statements across counselor-client gender pairings. *Journal of Counseling Psychology*, *26*, (6), 538-541.

McCarthy, P.R., & Betz, N.E. (1978). Differential effects of self-disclosing versus self-involving counsellor statements. *Journal of Counseling Psychology*, *25*, (4), 251-256.

McConnaughy, E. A. (1987). The person of the therapist in psychotherapeutic practice *Psychotherapy: Theory, Research, Practice, Training, 24*, (3), 303-314.

McCormic, R. W. (2017). *Influence of the Extent of a Therapist's Self-Disclosure of Previous Mental Illness on Client Perception* (Doctoral dissertation, Southern Illinois University at Edwardsville).

Merluzzi, T.V., Banikiotes, P.G., & Missbach, J.W. (1978). Perceptions of counsellor characteristics: Contributions of counselor sex, experience, and disclosure level. *Journal of Counseling Psychology*, *25*, (5), 479-482.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of Internal Medicine*, *151*, (4), 264-269.

Myers, D., & Hayes, J.A. (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy: Theory, Research, Practice, Training*, *43*, (2), 173-185.

Nahon, D., & Lander, N. R. (1992). A clinic for men: Challenging individual and social myths. *Journal of Mental Health Counseling*, *14*, (3), 405-16.

Nilsson, D. E., Strassberg, D. S., & Bannon, J. (1979). Perceptions of counselor self-disclosure: An analogue study. *Journal of Counseling Psychology*, *26*, (5), 399.

Nussbaum, K. J. (2014). *Therapist Self-Disclosure: A Phenomenological Study of Clients' Lived Experiences* (Doctoral dissertation, Walden University).

Patel, S. (2016). *An exploration of South Asian clients' experiences of therapist self-disclosure in individual therapy* (Doctoral dissertation, City, University of London).

Peschken, W., & Johnson, M. (1997). Therapist and client trust in the therapeutic relationship. *Psychotherapy Research*, *7*, (4), 439-447.

Picot, A., McClanahan, S., Conviser, J., Costin, C., Rabinor, J.R, Hornstein, R., McGilley, B.H. (2010). The therapist's appearance and recovery: Perspectives on treatment,

supervision and ethical implications. *Eating Disorders: The Journal of Treatment and Prevention*, *18*, (2), 165-175.

Rabassa, M. (2009). *Clients' experience of therapist self-disclosure within a CBT context: an interpretative phenomenological analysis* (Doctoral dissertation, University of East London).

Rao, N., & Mehra, A. (2015). Hurricane Sandy: Shared trauma and therapist self-disclosure. *Psychiatry*, *78*, (1), 65-74.

Risen, C. B. (2016). Boundary Crossings in Clinical Practice. In *Handbook of Clinical Sexuality for Mental Health Professionals* (pp. 22-31). Routledge.

Roberts, J. (2005). Transparency and Self-Disclosure in Family Therapy: Dangers and Possibilities. *Family Process*, *44*, (1), 45-63.

Rogers, C.R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin Company.

Rothstein, A. (1997). Symposium: Aspects of Self-Revelation and Disclosure: Analyst to Patient. *Journal of Clinical Psychoanalysis*, *6*, (2), 141-144.

Sainsbury Centre for Mental Health. (2006). *The Costs of Race Inequality: Policy Paper 6*. Sainsbury Centre for Mental Health.

Scior, K. (2017). *The HOP-MHP Project.* Retrieved from http://www.ucl.ac.uk/pals/research/cehp/stigmaresearch/documents/hop_docs/hop-mhp.

Shattell, M. M., Starr, S. S., & Thomas, S. P. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing*, *16*, (4), 274-284.

Sickel, A. E., Seacat, J. D., & Nabors, N. A. (2019). Mental health stigma: Impact on mental health treatment attitudes and physical health. *Journal of Health Psychology*, *24*, (5), 586-599.

Simi, N. L., & Mahalik, J. R. (1997). Comparison of feminist versus psychoanalytic/dynamic and other therapists on self-disclosure. *Psychology of Women Quarterly*, *21*, (3), 465-483.

Simon, J. C. (1988). Criteria for therapist self-disclosure. *American Journal of Psychotherapy, 42,* (3), 4434-415.

Smith, D., & Fitzpatrick, M. (1995). Patient-therapist boundary issues: An integrative review of theory and research. *Professional Psychology: Research and Practice*, *26*, (5), 499.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*, (2), 261-271.

Somers, A. D., Pomerantz, A. M., Meeks, J. T., & Pawlow, L. A. (2014). Should psychotherapists disclose their own psychological problems? *Counselling and Psychotherapy Research, 14*, (4), 249-255.

Sparks, E. (2009). Learning to be authentic with clients: The untold journey of a relational practitioner. In A. Bloomgarden & R. B. Mennuti (Eds.), *Psychotherapist revealed: Therapists speak about self-disclosure in psychotherapy* (pp. 163–179). New York, NY: Taylor and Francis Group.

Sparks, J.A., Duncan, B.L., & Miller, S.D. (2008). Common factors in psychotherapy. In J.L. Lebow (Ed.), *Twenty-first century psychotherapies: Contemporary approaches to theory and practice* (pp.453-497). Hoboken, NJ: John Wiley & Sons Inc.

Stack, C. (2013). Power and (in) equality in the UK's Armed Forces: implications for working with ex-military clients. *Counselling Psychology Review*, *28*, (2), 68-81.

Stiles, W. B., Caro Gabalda, I., & Ribeiro, E. (2016). Exceeding the therapeutic zone of proximal development as a clinical error. *Psychotherapy*, *53*, (3), 268.

Stricker, G., & Fisher, M. (Eds.). (1990). *Self-disclosure in the therapeutic relationship*. New York, NY, US: Plenum Press.

Sturges, J. W. (2012). Use of therapist self-disclosure and self-involving statements. *The Behavior Therapist, 35*, (5), 90-93.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ, US: John Wiley & Sons Inc.

Sue, D., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York, NY: John Wiley and Sons.

Tantillo, M.M. (2004). The therapist's use of self-disclosure in a relational therapy approach for eating disorders. *Eating Disorders*, *12*, (1), 51-73.

The British Psychological Society (2018). *Code of Ethics and Conduct*. Retrieved from https://www.bps.org.uk/news-and-policy/bps-code-ethics-and-conduct.

Van Voorhis, R. M. (2017). Feminist theories and social work practice. In *Human Behavior Theory and Social Work Practice* (pp. 271-296). Routledge.

Vasquez, M. J. T. (2009). Sometimes a taco is just a taco! *Professional Psychology: Research and Practice, 38,* (4), 406-408.

Vygotsky, L. (1978). Interaction between learning and development. *Readings on the Development of Children, 23,* (3), 34-41.

Watkins Jr, C. E., & Schneider, L. J. (1989). Self-involving versus self-disclosing counselor statements during an initial interview. *Journal of Counseling & Development*, *67,* (6), 345-349.

Wells, T.L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work*, *65*, (1), 23-41.

Yalom, I. D. (1975). *Theory and practice of group psychotherapy.* (2nd ed.). New York: Basic Books.

Yeh, Y. J., & Hayes, J. A. (2011). How does disclosing countertransference affect perceptions of the therapist and the session? *Psychotherapy*, *48*, (4), 322.

Ziv-Beiman, S. (2013). Therapist self-disclosure as an integrative intervention. *Journal of Psychotherapy Integration*, *23*, (1), 59.

Ziv-Beiman, S., & Shahar, G. (2016). Therapeutic self-disclosure in integrative psychotherapy: When is this a clinical error? *Psychotherapy*, *53*, (3), 273.

Ziv-Beiman, S., Keinan, G., Livneh, E., Malone, P. S., & Shahar, G. (2017). Immediate therapist self-disclosure bolsters the effect of brief integrative psychotherapy on psychiatric symptoms and the perceptions of therapists: A randomized clinical trial. *Psychotherapy Research*, *27,* (5), 558-570.

Zucker, S. A. (2014). *How clients in Alcoholics Anonymous experience therapist self-disclosure: An exploratory study*. Alliant International University.

Zur, O. (2007). Boundaries in Psychotherapy: Ethical and Clinical Explorations. Washington, DC, US: American Psychological Association.

Zur, O. (2011). *Self-disclosure & transparency in psychotherapy and counselling: To disclose or not to disclose.* Retrieved from http://www.zurinstitute.com/selfdisclosure1.html.

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*, (1), 22-30.

Chapter two: Empirical Research

What do people who have undertaken psychological therapy for their mental health think about therapists who disclose their own mental health difficulties during therapy?

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Abstract

Background: Personal experience of mental health difficulties is a common reason for pursuing a career in mental health (MacCulloch & Shatell, 2009). Whilst TSD of psychological distress is viewed as beneficial in some services (e.g. eating disorder, substances misuse), research is needed into TSD of mental health difficulties more generally (Cvetovac & Adame, 2017). Exploring the experiences of clients whose therapists have disclosed their mental health difficulties can provide guidance for therapists when considering mental health related disclosure decisions.

Objective: This study aims to understand how clients view psychological therapists who share their own mental health difficulties during therapy.

Method: Seven participants aged 18 to 50 years were recruited in the United Kingdom (UK) using social media. Face-to-face, audio recorded interviews were carried out at community centres. Data were transcribed and analysed using Interpretive Phenomenological Analysis (IPA).

Results: Participants described a range of experiences pertaining to their therapist's disclosure of their mental health, categorised into five main themes and sixteen sub-themes: 'What your disclosure says about me', 'the privilege of power', 'feeling conflicted', 'who is my therapist', and 'inspiration and hope'.

Conclusions: Participants' positive and negative experiences were identified as different dimensions of five constructs, indicating that TSD of a mental health condition can be experienced positively by clients, so long as therapeutic containment is preserved. Issues of power and privilege around disclosure decisions should be considered. This research offers a new contribution to the TSD literature and recommendations for further research are offered.

Keywords: "therapist self-disclosure", "counsellor self-disclosure" "mental health", "Qualitative research", "Interpretative Phenomenological Analysis"

Background

Mental Health in Therapists

Approximately 25 per cent of the general adult population in the United Kingdom (UK) have accessed mental health services, with this figure increasing to around 75% for UK mental health professionals (Bike, Norcross, & Schatz, 2009; Norcross & Guy, 2005). Personal experience of mental health difficulties has been found to be one of the most common reasons for pursuing a career in mental health (MacCulloch & Shatell, 2009), with early childhood experience being one of the main determinants for entering the therapy professions (Barnett, 2007; Cushway, 1996; Farber, Manevich, Metzger, & Saypol 2005). Other studies have indicated that psychologists may have greater experiences of childhood trauma compared to the general public (Elliott & Guy, 1993; Nikcevic, Kramolisova- Advani & Spada, 2007).

Therapist Self-Disclosure

Therapist self-disclosure refers to a wide range of verbal and non-verbal behaviours, which tells the client something about the therapist's personal context (Gibson, 2012); this could be for example, the wearing of a wedding ring, or sharing information about having accessed some form of healthcare. Audet (2011) distinguishes between immediate/ interpersonal TSD, revealing feelings about the client or therapeutic relationship, and non-immediate / intrapersonal TSD about the therapist's personal life, beliefs, attitudes or values. Non-verbal disclosures, for example attire and race, allow access to otherwise undisclosed information about the therapist (Zur, Williams, Lehavot & Knapp, 2009).

Whilst the British Psychological Society's Code of Ethics (BPS, 2018) and the Health and Care Professions Council's Standards of Practice (HCPC, 2016) emphasise adhering to personal and professional boundaries, there remains little professional guidance for therapists

considering self-disclosure as a therapeutic tool. Likewise, the literature around TSD and therapeutic boundaries is ambiguous, with some viewing intrapersonal TSD as a boundary crossing by shifting the attention away from the client (Ziv-Beiman, & Shahar, 2016), and others arguing that adhering to strict boundaries creates unhelpful power differentials (Van Voorhis, 2017).

Perspectives on TSD vary according to theoretical orientation (Peterson, 2002). More recently, there has been a shift from the 'blank screen' approach used in traditional psychoanalysis, with TSD now being used to provide corrective emotional experiences in relational modalities (Bridges, 2001), demonstrate therapist fallibility and humility in humanistic approaches (McConnaughy, 1987; Rogers, 1961), and reduce power differentials to promote equality by feminist proponents (Brown & Walker, 1990; Nahon & Lander, 1992; Mahalik, Van Ormer, & Simi, 2000).

Therapist Self-Disclosure of Mental Health Difficulties

Historically, therapists have been reluctant to talk about their mental health more broadly due to both stigma and fear of negative evaluation from others (Zerubavel & Wright, 2012). Development of recent initiatives such as the 'Honest, Open and Proud' framework (Scior, 2017) has generated growing interest in this area. Initially developed in the United States and now being used in the United Kingdom (UK), this aims to support professionals to share their own lived experiences of mental health difficulties, breaking down the 'them and us divide'.

Whilst therapists sharing their own mental health difficulties may be welcomed by other professionals, with resolved psychological woundedness being viewed positively when considering applicants for clinical psychology training programmes (Ivey & Partington, 2012), therapists have reported feeling more comfortable sharing their own woundedness with clients than with colleagues or peers (Wright, Seltmann, Telepak, & Matusek, 2012).

Whilst evidence suggests that therapists working in eating disorder (Picot et al, 2010) and substance misuse (Ham, LeMasson, & Hayes, 2013) services do share their own experiences of psychological distress with clients, there remains little guidance for therapists considering whether or not to disclose such information.

The literature on TSD to date has not provided an understanding of the issues around TSD of a mental health condition to their clients either outside of, or during, therapy. Understanding more about why therapists may be reluctant to speak about their own mental health difficulties can help reduce stigma (Zerubavel & Wright, 2012) and encourage open discussion around a therapist's own difficulties that promotes recovery and fosters support. This is particularly important given that therapists are well positioned to influence societal views on mental health (Schulze, 2007).

Objectives

The aim of this research was to understand how people who had experienced their therapist disclose to them about their own mental health during therapy made sense of this experience. In particular, it aimed to understand how therapists who have experienced their own mental health difficulties are viewed by their clients, as well as exploring the impact of the disclosure on the client. To date, therapist perspectives on TSD within the academic literature remain dominant. Yet, for TSD to be helpful for clients, we must create space for their voices to be heard. This is an important next step in 'de-centring' the therapist and exploring the views of people who access services, and whose experience should be central to professional guidance, actions, and reflections.

Method

Research Approval

Ethical approval for the study was obtained from the University of Liverpool Clinical Psychology Research Review Committee (Appendix B) and the University of Liverpool Research Ethics Committee (Appendix C). An Expert by Experience Clinical Advisor was consulted throughout the study to ensure that all materials used were appropriate.

Design

A qualitative design was used and a purposive sample of both men and women sought. The inclusion criteria for participants in this study were individuals over the age of 18 who: (a) had previously undertaken an unspecified psychological therapy for their mental health (b) were not currently in therapy (c) whose therapist shared their own mental health difficulties with them during therapy, and d) that their therapist accessed either psychological, psychiatric and/or pharmacological treatment for these difficulties and shared this with them.

Recruitment

Participants were recruited purposively from UK community/third sector organisations and via social media sites Twitter and Facebook (Appendix D), service user forums, community settings (drop in centers), and via advertisements on Liverpool University's Campus, including Student Support Services (Appendix E). Seven participants (4 female, 3 male) aged between 18 and 50 years were recruited from various areas in the United Kingdom. All responded via Twitter or directly via email to say they had seen the advertisement on Twitter.

All identified as White-British with the exception of one who identified as Asian or Asian British with Pakistani Heritage. Table 1 shows participant information.

Procedure

Participants contacted the researcher by email or social media. If they met the inclusion criteria they were provided with a participant information sheet (Appendix F) via the researcher's University email. If they decided to participate, informed consent was sought (Appendix G) and GP details taken (Appendix H) at the interview to safeguard against concerns arising during participation. Semi-structured, face-to-face interviews lasting between 45 and 70 (mean length 52 minutes) were carried out using a topic guide (Appendix I) between May 2018 and January 2019 at the University of Liverpool, Community Centres across the UK, public libraries and offices that could be rented hourly. The researcher arranged this by contacting the venues directly. Costs occurred for room space ranged from £13 to £25 per hour.

Participants currently accessing a mental health service had the option to be interviewed at home and consent was sought to contact their GP or service provider to ensure a home visit was safe. This option was not available for those participants not currently under a mental health service, given that healthcare records may not have been up to date regarding risk and safety information.

Participants could take breaks and stop the interview at any time. A debrief sheet (Appendix J) and £10 gift voucher were provided at the end of each interview in recognition of participants' time. Participants also completed a demographic questionnaire (Appendix K). Interviews were audio recorded and transcribed by the researcher using a secure transcription software package. Audio recordings and transcriptions were anonymised and stored on a secure server at the University of Liverpool and password protected on the researcher's personal computer.

Participants' demographic information was recorded (Appendix K). A topic guide was developed to guide interviews (Appendix I). Key areas explored were a) thoughts and

feelings about seeing a therapist and therapy b) experience of the disclosure itself c) views on therapists with mental health difficulties d) the therapeutic relationship both prior to, and following, the disclosure.

Analysis

Data were analysed using Interpretive Phenomenological Analysis (IPA), a qualitative methodology that explores an individual's personal perception or account of an event (Smith, 1996) widely used within British psychological research (e.g. Clare, 2003; Biggerstaff, 2003). Epistemologically, it takes an interpretivist paradigm whereby an individual's world is socially constructed and knowledge is based on perception, rather than an objective truth. As the researcher brings their own interpretations and assumptions to the data, conclusions are derived from these interpretations as opposed to existing theories.

The analysis of transcribed interviews followed IPA recommended stages (Smith, Jarman, & Osborn, 1999). Interview transcripts were read and re-read to gain a sense of the participant's experience, noting preliminary interpretations which were used to form emergent themes (Appendix L). An audio recording was reviewed by each supervisor, and both audio recording and transcript (Appendix M) by one supervisor to confirm credibility of emergent themes which was used to form sub and superordinate themes. The remaining transcripts were analysed in the same way, noting similarities and differences to earlier interviews and new emergent themes. Abstraction (Smith, Flowers & Larkin 2009) was used to group sub and superordinate themes together to form master themes across all interviews.

Reflexivity

As a White, female Trainee Clinical Psychologist with personal experience of mental health difficulties, and having used both immediate and non-immediate self-disclosure with her own clients during therapy, although not regarding my own mental health, I was curious

as to how clients may experience this. Being both comfortable and relatively confident in its use therapeutically, prior to undertaking the research and during, I was generally in support of its use with clients, when thought to be appropriate. Consequently, my own personal and professional experiences, attitudes, beliefs and values would have inevitably influenced interpretation of data. Access to regular supervision, a reflective diary (Appendix M) and a transparent analysis with a clear audit trail helped mitigate against this.

During analysis, my views on TSD changed, particularly around TSD on social media platforms, as reflected on in the discussion. Whilst I anticipated that therapists disclosing their own mental health difficulties would elicit a range of responses, I was not prepared for the compassion shown by most participants when hearing of their therapist's challenges. Despite challenging many of their own assumptions about therapists, I was surprised at how unsurprised participants were upon hearing their therapist disclose.

Quality Assurance and Validity

Quality assurance methods included keeping a reflexive diary and on-going discussion during supervision to reflect on my contribution to the co-construction of meaning-making. The process of analysis and emergent themes were reflected on with two supervisors; the primary supervisor in person, and the secondary over email. Regular face-to-face meetings were held with the primary supervisor and on-going discussion, thoughts and reflections were discussed collaboratively by email with both supervisors.

Yardley's (2008) framework for quality in quantitative research was utilised pertaining to four principles: sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance. Sensitivity in context was demonstrated by being considerate of my relationship with participants, as both researcher and clinician and attentive to corresponding issues of power and privilege around TSD, as well as the sociopolitical

context of participants' individual experiences that may have influenced their views. The systematic process employed to the analysis of data demonstrated commitment and rigor, whilst transparency and coherence was attained through an open, transparent and collaborative sharing of reflections, suggestions and analytic processes with supervisors, supported by a clear audit trail. Finally, impact and importance were adhered to through translation of findings to clinical practice, as discussed in 'clinical implications'.

Table 1: Participant Information

Name	Gender	Age Range	Ethnicity	Occupation	First time of therapist's disclosure	How my previous times in therapy
Evelyn	Female	18-30	White/White-British	Part-time employment	No	Two
Arabella	Female	18-30	White/White-British	Part-time employment/student	Yes	Two
Lilly	Female	41-50	White/White-British	Full-time employment	No	Three
Adriana	Female	18-30	White/White-British	Student	Yes	Unknown
Gabriel	Male	41-50	White/White-British	Unemployed	No	More than three
Tristian	Male	41-50	White/White-British	Signed off/voluntary work	No	Two
Luca	Male	41-50	Asian/Asian British/Pakistani	Full-time unpaid carer	Yes	Three

Note: Participant names have been changed

Table 2: Therapist and Therapy Information

	Therapist Characteristics			***Therapy Characteristics***	
Name	Therapist's mental health difficulties	Therapist Type	Gender	Model of Therapy	Point of disclosure (sessions)
Evelyn	Depression, self-harm	Counsellor	Female	Person-centered	1-4
Arabella	Anxiety, depression, body image, trauma	Counsellor	Female	Counselling	9-12
Lilly	Depression	Counsellor	Female	Unknown	Unknown
Adriana	Depression	Psychotherapist	Female	CBT	Unknown
Gabriel	Anxiety, Depression, unresolved grief/loss	Counsellor	Male	CBT, Cognitive Analytic Therapy (CAT), Integrative Therapy	5-8
Tristan	Obsessive Compulsive Disorder	Psychotherapist	Male	Behaviorism	16+
Luca	Anxiety, depression, paranoia	Counsellor	Male	CBT	1-4

Note: Participant names have been changed.

Results

Figure 3: Table of Super-ordinate and Sub-themes

Super-ordinate themes	Sub-themes
1. What your disclosure says about me	1.1 The type of person I am
	1.2 The type of person my therapist is
	1.3 Perceptions of mental health diagnoses
	1.4 Is my therapist is ok?
2. The privilege of power	2.1 You are right there with me
	2.2 Having a voice
	2.3 Feeling like a therapist
3. Feeling conflicted	3.1 Comparison and feeling judged
	3.2 Normalized, validated and understood
4. Who is my therapist?	4.1 The 'person and the 'professional'
	4.2 Some things you can't teach
	4.3 Challenging assumptions
5. Inspiration and Hope	5.1 Therapist as role model
	5.2 If you can do it then so can I

Super-ordinate theme 1: What your disclosure says about me

This theme captures the range of unique factors impacting upon participants' experience of their therapist disclosing their own mental health difficulties.

1:1 The type of person I am

Participants described how their own personalities and other characteristics, such as professional background and mood at the time of the disclosure impacted upon their experience of it.

Tristan, for example, describes how his highly empathic nature might lead him towards worrying about his therapist's mental health, following their disclosure: *"Because I worry about myself and other people…can overly emphasise to the point of inertia, it might be problematic that I might then worry about their well-being."*

Lilly, however, felt being a healthcare professional increased her robustness upon hearing her therapist disclose: "*I think if I was more fragile it might have changed my perception… I don't know how much of my mindset comes from being a professional as well".* In contrast, Gabriel found hearing about his therapist's own struggles was difficult because of where he was emotionally in therapy: "*The raw aspect of it was that he was mentioning certain things I was going through in that moment. He was in a different position to where I was."*

1.2 The type of person my therapist is

Individual characteristics of the therapist, such as age, appearance and demeanour, influenced participants' views on the disclosure.

Evelyn reflects on how a similar aged or younger therapist disclosing their own mental health difficulties may have led to comparison and feelings of inadequacy, when she

states: "*If they have overcome it and are the same age or younger than me, like why haven't I, so I wouldn't have found that helpful at all, that would have done my head in*."

Similarly, Adriana describes how both her therapist's gender and age influenced her perceptions of their genuineness based on her own relational style, which enabled her to feel at ease with their disclosure: *"I do tend to get on with men a bit better than women, and yeah, maybe because he was a little bit older it was more genuine…younger people tend to be a bit more eccentric, and obviously like the older, it's more like your Grandad sitting in a chair."*

For Arabella, however, her therapist's appearance and demeanour helped her to feel safe when she states: "*She had like bleach blonde hair, dead sassy, dead tanned…she was like 'oh you're with me', and I was like 'OK well that makes me feel a bit better.'"* This emerging therapeutic alliance helped form positive experiences of her therapist's disclosure later on in therapy.

1.3 Perceptions of mental health diagnoses

Participants alluded to a range of different views on mental health, and particularly the type of mental health difficulty disclosed and how they felt about this.

Lilly, for example, captures the impact certain types of mental health disclosure would have had on the therapeutic relationship when she states: *"borderline personality disorder…that's going to change the way we interact, I'd have to consider policing boundaries a little more."* Gabriel describes a similar experience of feeling guarded when he refers to his therapist being on antidepressants in the following description:

I would have felt worse if I had known he was on antidepressants, because if I have come out and said something, I was worried about triggering a situation, would it be the point of 'oh quick I've got to run for the antidepressants.

Likewise, for Adriana, the type and number of mental health difficulties disclosed influences her views on the severity of her therapist's mental health; with increased severity impacting on her emotional well-being and removing the focus away from her, captured in the following description:

With something like psychosis, like schizophrenic, or voices, I'd definitely be more concerned about them and that takes away from my time…I wouldn't know what to do and then get anxious…If he'd have said like more than the one, I would have been like, 'bloody hell, I don't want someone that mad', not in a nasty way, but you know, because at the time, I felt like I didn't know what's going on, maybe I would have felt overwhelmed.

Tristan, however, had a different perspective, reflected in his comment: "*It's not condition specific for me; it's what they are saying and how they are acting."*

1.4 Is my therapist ok?

Participants described how the nature of the disclosure, in terms of its frequency, congruence, duration and disclosure of current or past mental health difficulties, influenced how they viewed their therapist's emotional well-being; eliciting feelings of worry and a need to know they were 'ok'.

Tristan captures the importance of needing to know his therapist is coping when he states: *"If they had gone into a full-blown issue and are disclosing things that show they aren't coping in the here and now, then I would feel like I have to pass that on".*

Likewise, Evelyn shares similar experiences of triggering her therapist, eliciting feeling of worry and a pre-occupation with the therapist's well-being: "You're *scared to say some stuff in case it like triggers things for them…your mind just like runs away with you…it makes you worry about them."*

For Adriana, the frequency and extent of the disclosure impacted how she felt about it: *"If they go on and on or bring stuff up, I think it would make me uncomfortable."* She elaborates by alluding to the emotional burden she would feel in knowing her therapist was currently struggling, captured in the following description;

> *If it was happening now, I wouldn't be equipped to deal with that, because I'm not a therapist…I'm not part of the mental health team… if it's something severe it could make you feel worse…if someone describes something like that, I wouldn't even know what to do.*

Similarly, Lilly emphasises the congruence of her therapist's disclosure: *"My second therapist spoke about her depression, but it was always in relation to mine."*

Super-ordinate theme 2: The privilege of power

This theme captures the range of experiences relating to how participants felt the therapist's disclosure impacted upon the therapeutic relationship, including therapeutic boundaries and roles, trust and intimacy. The interaction of power and control of the therapeutic conversation interacts with decisions about what, when, and how to disclose.

2.1 You are right there with me

Participants described an increased sense of trust and connectedness to their therapists following their disclosure, which strengthened the therapeutic alliance.

Gabriel, for example, found comfort in familiar words and phrases through a shared language around his own and his therapist's difficulties, beautifully captured in the following description: "*And that sort of aspect when he said it brought me to my knees, that's what I used to say, and he said exactly what was in my head, so it was lovely. It was very strange".*

The increased sense of connectedness and trust following the therapist's disclosure is reflected in an experience provided by Arabella: *"Because she knew on a personal level, I found it a lot easier to accept what she was saying…she was able to identify, and I was able to identify with her more because I knew that she knew".*

2.2 Having a voice

Issues of power were especially evident in participants' accounts of how they navigated uncomfortable emotions following the disclosure, captured by Gabriel's description below:

> *I never really got to ask, I suppose I was quite frightened to in the sense of did I just worry you then. I suppose if I've had a little bit more courage… I felt powerless to say to the person why did you look like that, or why did you seem like that.*

Luca provides a striking and somewhat saddening description of the sense of powerlessness he felt from being unable to voice his frustrations that were in conflict with the gratitude he felt from receiving 'free' therapy:

> *I used to get a bit of insight subconsciously, annoyed, frustrated and think God you told me this last time…when you get a free service it's like beggars can't be choosers. I was showing a lot of gratitude that I was getting something, like support that didn't cost anything because I couldn't afford it.*

For others, their therapist's disclosure helped balance power differentials and helped them to feel empowered, as Evelyn describes: *"It sort of made the relationship more balanced, sometimes it feels like there's like a power difference… it didn't feel like that it felt really balanced, like we were both on the same page."*

2.3 Feeling like a therapist

At times, therapeutic roles and boundaries became blurred for participants following their therapist's disclosure, leaving participants confused as to what they should do and at times feeling like both a client and therapist.

Below, Luca provides a powerful description of how he felt compromised between supporting his therapist and himself:

> *It became more like, crying and wiping the tears, crying and wiping the tears, he had his story to tell and I had mine to tell, and together we would wipe each other's tears, and I didn't really want that.*

Others such as Lilly, felt therapeutic roles were not jeopardised following their therapist's disclosure, and continued to feel contained within the therapeutic relationship: *"She wasn't emotional with it, she was very calm…very clear and professional. So she was the grown up and I didn't have to be."* And despite having a positive experience, Lilly reflected on how boundaries could also be maintained through non-disclosure, which for her, was also fine: "*It's not my job to know if they've got bipolar or psychosis or anything, my job in that space is actually to be the person in the centre."*

Super-ordinate theme 3: Feeling conflicted

This theme captures the emotional experience of participants following the disclosure, including the impact on the self and how they felt in relation to their therapists.

3.1 Comparison and Feeling Judged

Participants described a range of feelings and experiences pertaining to how they felt in comparison to their therapist, either following the disclosure, or more generally. They also expressed fears around what their therapist would think of them or their difficulties, and how their own disclosures might impact them.

Gabriel, for example, describes below his sense of worry in comparing whether his own ways of coping with his distress were 'right', in comparison to his therapists:

> *I remember him sort of sitting back and saying like 'oh do you do that a lot'...And he sort of physically winced, so then I worried in the sense of whether that was wrong for me, whether I'm doing the wrong thing.*

Whilst Evelyn also describes feelings of comparison when she states: *"If the stuff you're upset about or want to complain about isn't really that much of a big deal compared to what they're going through, you sort of feel like you can't talk about it",* these were related to the severity of her therapist's distress compared to her own, leading to feelings of guardedness.

For others, knowing their therapist had experienced mental health difficulties helped them to feel reassured and less shame over their own distress, as Adriana describes: "*If I thought this man was perfect and I'm sitting here with all my problems talking about them that would make me feel worse".*

3.2 Normalised, Validated and Understood

Most participants described a shared experience of feeling heard by their therapists on a deeply personal level, leaving them feeling understood, more at ease with their own distress and able to open up.

Here, Adriana describes how knowing her therapist had experienced mental health difficulties provided reassurance when she felt confused and scared about her own experiences: *"It did make me feel like better, like, maybe being like ok I'm not actually losing the plot, like, that happened to me too".*

Tristan captures the experience of feeling validated and understood on a personal level when he states *"There was a certain validation to my experiences and that just felt very congruent, very real…he had a very nuanced view of me specifically…it felt like here is someone who really listens and understands."*

In her account below, Arabella demonstrates how her therapist used their disclosure to encourage her to 'open up' when she was guarded and closed off.

> *I was just sat there, with my arms crossed, like just not interested…then she kind of like, disclosed her stuff, I was like, 'oh, yeah, that makes me feel better like', and then I was a bit more open with her…I don't think I would have said half as much as I did, if she hadn't said anything.*

Super-ordinate theme 4: Who is my therapist?

This theme captures how participants made sense of their therapist's identities and their own views and assumptions about them, both prior to, and following the disclosure.

4. 1 The person and the professional

Participants described a range of experiences relating to the separation and/or amalgamation of the personal and professional identities of their therapists.

Tristan conveyed the importance of his therapist's humanity in being a fundamental part of therapy when he stated "*The art of psychotherapy for me beyond the science is that human touch*". For him, his therapist's ability to be a therapist, despite their mental health difficulties, was paramount: *"As long as the therapist is functional and well enough to be a therapist and any disclosures they make are appropriate, then I'm very much for it…it fits on a recovery model for me".*

Whilst for Lilly, the personal and professional lives of therapists were viewed quite separately, and being a healthcare professional helped her to see both sides, as described in the account below:

> *If you don't spend time with health professionals as people, if you only see them as your team, then it's a different… you would see just the uniform and nothing passed it, but wouldn't really be thinking about what they do outside of that.*

In the account below, Luca expresses similar views on the separating of identities, although unlike Lilly, feels that sharing of the 'personal' with regards to mental health, could negatively impact the credibility of the therapist:

> *It's almost like your professionalism as the counsellor is now wiped off and you're seen as a person who has had a mental health breakdown, suffered depression or been through psychosis and that professional counsellor status that brought you to them suddenly doesn't mean anything.*

Evelyn, however, describes a curiosity and pre-occupation around wanting to see the 'person' of the therapist in stating: "*I wanted to know more about her because like I was telling her all this stuff, but I knew that like she wouldn't like disclose anything, an erm, I sort of felt like I was always wondering."*

4.2 Some things you cannot teach

Evidently, participants' accounts emphasised strong views around therapists' experience, discriminating between that which was both taught, and lived.

In stating *"It's our individual experience that's the biggest evidence base for therapy I think"*, Tristan conveys a powerful message about the importance of the therapist's personal experience in determining the effectiveness of therapy.

Whilst for Adriana, knowing her therapist had experienced similar difficulties with their mental health increased feelings of therapeutic validity and credibility, as provided in her account below:

> *If I asked a question, like did you think that, did you feel that, and someone was like 'I don't know', I would be like well why am I listening to your advice, why am I doing these things because you don't know how I'm feeling right now… I'd probably take it all more with a pinch of salt, I'd feel like I was getting lectured.*

Gabriel distinguishes between therapists who have had personal experience of mental health difficulties and those who have not: "*You can tell people who have not had experience in the particular field because, you just can, it's very text book, you know it's very clinical".*

4.3 Challenging assumptions

Certain views and assumptions about their own, and therapists in general, were held by participants prior to the disclosure. All depicted a common theme of an 'all knowing, prefect therapist', which was challenged upon hearing their therapists' disclose about their own mental health.

Luca shares his assumptions about therapists using their own strategies to cope in his account below:

> *Somebody who has gone through professional training as a counsellor will be really good at sorting their own lives out, their own problems. I thought counsellors don't have problems because they've got all the strategies, the tools, methods to find ways to cope.*

For Arabella, initial impressions of her therapist were challenged upon hearing about her own distress: *"She seemed like she had it all together, she was like dead cool and sassy, and I was like oh my god she has to have had the best life*."

Similarly, Adriana's image about what therapists and therapy were like prior to the disclosure was different to how she imagined:

> *Like a middle-aged man…like geography teacher people…just a room with a clock ticking, you know, 'how do you feel...how you feel about that', I thought it would be like, that but it wasn't…I never really thought of therapists as people who would go through that, I just thought it was people who were like quite book smart.*

Super-ordinate theme 5: Inspiration and Hope

This theme captures the sense of positivity participants experienced following the disclosure pertaining to their own future and mental health.

5.1 Therapist as role model

Participants alluded to their therapists becoming a role model for them in terms of their own recovery, whether through admiration or following things that had helped them when they were unwell.

Arabella, for example, describes how knowing her therapist had taken medication for her mental health encouraged her to explore this too: *"You could ask about anti-anxiety medication, so I did, and that's helped so much…if she hadn't told me about it I never would have thought that."* Lilly offers a similar experience relating to the sharing of her therapist's coping strategies when she says '*She said I've had periods of depression, I found this useful, what did you think about that…that type of suggestion, so it was much more about this is a tool you can use that I found useful."*

4.4 If you can do it then so can I

This theme reflects how the therapist's disclosure was experienced positively by participants in terms of them feeling inspired by it, providing them with a sense of hope for their own recovery and path in life.

This sense of hope is captured by Evelyn when she states *"I think it gave me like hope as well that if she was like able to get through those things then I'd be able to as well."* Whilst Arabella also felt both reassured and motivated that her mental health difficulties did not have to prevent her from doing what she desired: "*If that happened to her, and she's still*

really like successful and suffers with anxiety and whatever and still doing really well, that made me feel better…that could happen to me as well."

Finally, the positivity felt from Adriana's description below is warming and really captures the importance of *who* therapists are to their clients and the impact that sharing the 'personal' can have in providing a sense of hope for people at a time when all may feel lost.

> *He's about 25 years older than me and he's getting to where we want now, why can't I do that even if it takes me 5/10…it's the little things like that if they mention during therapy, it gives you an extra boost, to be like ok, I can do that, he's had low mood, even though it's not the same as me, he's done alright hasn't he.*

Discussion

This study explores clients' experiences and views of TSD of a mental health condition during therapy. It adds a unique contribution to understanding what clients undertaking psychological therapy for their mental health think about a) therapists with their own mental health difficulties and b) therapists who disclose these during therapy. Current literature in this area is sparse, focusing on clients' perspectives of TSD more broadly, and failing to discriminate between various types of TSD, in terms of content and the intricate nature of this.

Participants comprised a small group of men and women of various ages who had experienced their therapist disclose their own mental health difficulties during therapy. They described a range of factors, unique to their own and therapist's characteristics that impacted upon their experience of the disclosure. Consistent with previous research (e.g. Rabassa, 2009), both participants' personality characteristics and mood at the time of the disclosure influenced how they experienced it. Whilst less research has looked at the influence of therapist characteristics on TSD, participants in this study described how their therapist's age, appearance and demeanour influenced the therapeutic alliance which later impacted their experience of the disclosure. This supports the existing literature in suggesting the therapeutic alliance is imperative in determining how clients experience TSD (Audet & Everall, 2003; Wells, 1994). For some participants, such characteristics influenced assumptions about their therapist and their lifestyle, pertaining to the image of a 'perfect' therapist who 'had it all together'. Such assumptions were later challenged through the disclosure, which increased their sense of connectedness to their therapist.

Unique to this study, however, was the nature of the disclosure around mental health specifically and how participants felt about the type of mental health difficulty their therapist

disclosed. Some participants held pre-existing assumptions and views around mental health that affected how they viewed their therapist and managed the disclosure. Certain diagnoses, for example Borderline Personality Disorder and Psychosis, along with medication use, were associated with increased perceived severity of their therapist's mental health. This shifted some participants into a position of uncertainly, with a focus on managing boundaries and a pre-occupation with the therapist's mental health, as opposed to their own. Such experiences are consistent with wider societal stigma and views around specific mental health difficulties (Isaksson et al, 2018), with both Borderline Personality Disorder and Psychosis being heavily stigmatised amongst the general population and mental health professionals (Knaak, Szeto, Fitch, Modgill, Patten, 2015).

For others, their therapist's demeanour during sessions was more important than the type or severity of the mental health difficulty disclosed. This supports previous research which advocates that the *person* of the therapist is an important determinate of a strong therapeutic alliance and therapeutic outcome, and is consistent with non-specific therapeutic factors being a fundamental aspect of therapeutic change (Zilcha-Mano, Roose, Brown & Bret, 2018). Similarly, whilst consistent with previous literature (Audet & Everal, 2003; Barrett & Berman, 2001,), both the frequency, congruence and duration of the disclosure influenced how participants experienced it; of fundamental importance to them was knowing that their therapist was 'ok'. Therapists who talked at length about their mental health or frequently commented on it, elicited feelings of worry in participants. Likewise, whilst disclosure of current mental health difficulties was experienced more cautiously compared with past, participants were nevertheless reassured knowing that their therapist was able to cope in the 'here and now'. This may be due to pre-defined roles and assumptions around therapeutic roles and particularly around assumptions about how a therapist is expected to be, whilst also demonstrating the importance of containment for clients in therapy.

Issues of power were strongly narrated in participants' experiences, as accounted for in previous TSD studies (e.g. Knox, Hess, Petersen & Hill, 1997; Wells 1994). Yet, perhaps the novel finding in this study was the therapist's degree of power which overarched into the therapeutic dynamic and decisions around what, when and how to disclose. As reflected in most participants' accounts, when disclosing their own mental health difficulties to their clients, therapists had the power to strengthen the therapeutic alliance and balance power differentials, alter boundaries and place clients in a situation they felt unequipped to manage. Whilst some participants experienced an increased sense of trust and connectedness to their therapist following the disclosure, others felt the shift from feeling like client to both client *and* therapist through role reversal jeopardised the therapeutic alliance and left them feeling confused. Although previous studies indicate TSD can impact upon the therapeutic alliance (Hanson, 2005) and alter boundaries (Audet, 2011), the most poignant aspect of this is the sense of powerlessness some participants felt in not being able to share their discomfort with their therapist. Likewise, consistent with feminist perspectives on TSD (Mahalik, Van Ormer, & Simi, 2000), the emphasis of power within the therapeutic relationship was emphasised through several participants reporting that the disclosure helped them to feel more equal to their therapist.

This highlights the inherent nature of the therapeutic relationship and how it can never truly be equal. Ultimately, as the ones holding power, therapists have a responsibility to use TSD wisely to mitigate against the potential for further power imbalance. Fundamentally, the decision to disclose or not lies with the therapist, not the client, emphasising the privilege of TSD and one that is not granted to clients in therapy.

Polarised feelings in participants were also evident in the conflict they felt around feeling understood and validated, knowing their therapist had experienced mental health

difficulties, yet feeling a sense of comparison to their therapist. Whilst some participants described feeling fearful of opening up to their therapist in case their difficulties were not as significant as their own, others felt that their therapist's disclosure had helped them to feel less shame around their own difficulties and sharing them as they knew they would not be judged. This is consistent with existing literature surrounding the importance of the therapist's fallibility and how this can be used effectively through TSD to strengthen the therapeutic alliance (Hill, Knox & Pinto-Coelho, 2019).

Making sense of who their therapist was, seeing them as both a person who had experienced mental health difficulties, and a professional, was important to participants. Their therapist's disclosure challenged assumptions about therapists and they felt strongly about the importance of the therapists' own personal experiences in determining their credibility. Participants alluded to fundamental differences between those therapists who had their own experiences of distress, and those who did not, which impacted upon how therapy was delivered and their experience of their therapist. For many, the therapist's own distress was experienced positively by participants in terms of the therapist's person-centeredness and humility, which became an integral part of their therapy. Participants contrasted this with a more 'text book' way of doing things, by therapists without mental health difficulties. This provides support for the wounded healer archetype in demonstrating the power of the therapist's own wounds to promote the healing of their clients (Sedwick, 2016), and demonstrates the importance of the therapist's personal qualities and genuineness for clients in therapy. Importantly, it also highlights the significance of non-specific factors in therapy, TSD being one, which can determine therapeutic outcome as opposed to adhering rigidly to specific models that may be experienced as artificial by the client.

Knowing their therapist had experienced mental health difficulties provided participants with a sense of hope for the future pertaining to their own mental health. Participants described how therapists became a role model for them through sharing things that had helped them with their own recovery and creating space to consider other possibilities. This is consistent with Cognitive Behavioural approaches around TSD that are centred on modelling helpful ways of being for clients (Goldfried, Burckell & Eubanks-Carter, 2003). People may enter therapy at a time when all seems forlorn, questioning their purpose and direction in life (O'Hara, 2011). Sharing of the therapist's own mental health difficulties and/or other distress can therefore act as a buffer against this, and may facilitate increased levels of motivation for clients in therapy.

Strengths and Limitations

This is the first study to explore clients' experiences and views of TSD of a mental health condition during actual therapy. It therefore adds a novel contribution to the TSD literature. Furthermore, whilst therapists may allude to having similar mental health experiences to their clients, for example, 'I get anxious too' as a way of normalising their difficulties, such comments may be ambiguous and are fundamentally different to a therapist who explicitly states that they were diagnosed with a mental health condition, for which they received help for. It is the latter that we know less about and which this study explored.

Still, there may be therapists who have experienced significant psychological distress, yet do not identify with having a diagnosable mental health condition. From a social constructionist perspective, mental health diagnosis and/or labels are constructed through ideological systems and created by individuals and groups who produce their own conceptions of reality (McLeod & Chaffee, 2017). Given that mental health diagnoses are strongly embedded in Westernised cultures, this study may not be generalisable to non-

Westernised philosophies. Additionally, the experiences of clients whose therapists have disclosed psychological distress without a diagnosed mental health condition may well be different. As this study demonstrates, disclosure of certain diagnoses conjures different responses from clients and language used around mental health may influence how clients experience their therapist's disclosure.

The study was also advertised across a range of forums, including generic social media sites such as Twitter and in-service user-lead groups and mental health community centres, making it accessible to a range of people. Likewise, being a national study increased the chances of widening diversity in the sample and as the researcher travelled to the participant, it provided people with the opportunity to take part in the research who may otherwise not have been able to.

Nevertheless, this research offers an interpretive account of clients' experiences of their therapist sharing their own mental health difficulties during therapy. It is a subjective account of a small group of relatively homogenous individuals, and generalisability is therefore limited. Although stated as part of the inclusion criteria, there was no way of confirming whether or not the therapist's mental health difficulty was diagnosed and they received treatment for it. Furthermore, whilst the ratio of male to female participants was near equally distributed, ethnic diversity was a major limitation given that six out of seven participants were White, with previous research indicating that ethnic minority clients may have different needs around TSD (Sue & Sue, 2003).

Nonetheless, given the intimate nature of TSD, this study provides rich accounts of clients' experiences and lends itself well to a qualitative methodology. Regular reflection and supervision reduced the effects of researcher bias, as did the skills of the researcher being a Trainee Clinical Psychologist and reflective practitioner. The relative position of the

researcher in conjunction with participants' experiences, however, may have meant participants presented themselves in a certain way, knowing that the researcher was a therapist herself.

Clinical and Wider Implications

The findings of this study indicate that therapy clients find their therapist sharing their own mental health difficulties with them beneficial, so far as it is done in the right context. Fundamentally, clients' overarching need is to feel contained and safe within the therapeutic relationship. Therapists should therefore prioritise this when considering disclosure decisions. The type of mental health difficulty disclosed, along with the congruence, duration and frequency of the disclosure are important. Therapists should pay careful consideration to disclosures which may increase the risk of the therapeutic space feeling uncontained for clients, particularly around disclosure of current mental health difficulties and those which may be perceived as more 'severe' (e.g. psychosis). Equally, given that therapists are well positioned to influence societal views on mental health (Schulze, 2007), disclosing of difficulties viewed as more severe may be beneficial to breakdown the client's internalised stigma. From this perspective, it should be encouraged, so long as it is considered and containment for the client is reflected upon during supervision.

Given that issues of power were strongly narrated throughout participants' accounts, therapists should be attentive to this and the inherent power that they have over their own disclosure decisions concerning their mental health. This is a sensitive area and having such power over what to disclose and to whom, is a privilege that may be denied to our clients whose personal mental health narratives are documented and shared amongst professionals. Of particular significance is how therapists, psychologists and other mental health professionals choose to disclose and to whom. The recent movement of initiatives such as the

'Honest, Open and Proud' programme have seen such professionals start to talk openly and publicly about their mental health in a range of forums. Whilst this is without doubt positive, well-intentioned and aimed at reducing stigma and a 'them and us divide', it nevertheless risks further marginalising those who have accessed therapy and wider mental health services by reminding them of how they were not granted the choice of whether to disclose. Contextually, when making mental health-related disclosure decisions, both during and outside of therapy, professionals should be mindful of the reasons for doing so and ensure that this is done in a way that is sensitive to issues of power. Historically and to date, therapy professionals and clinical psychologists particularly compromise those from advantaged backgrounds. Although well intended, therapists disclosing their own mental health difficulties may be perceived as colonising the space of those they serve in the call to validate their own distress.

Finally, there are clear benefits from therapists sharing their own mental health difficulties during therapy and TSD of this nature could almost be considered an intervention itself. Therapists should be attentive to *who* they are to their clients, and how they can use their own personal attributes and narratives to strengthen the therapeutic relationship and increase their client's emotional well-being. In a world where there is an ever-increasing emphasis on adhering to evidence-based models, structures and practices, this aspect of therapy should not be underestimated and according to the participants in this study, is actually the most fundamental part of therapy. Therapists may be open to showing their own fallibility to clients through self-disclosure of their own distress, but for this to be useful to clients, it must be sensitive to their individual needs and attributes, be containing, thoughtful, and considerate of issues of power and privilege around TSD.

Future Research

Further research would benefit from further exploration of TSD of mental health difficulties from the therapist's perspective, and ideally therapist-client dyads given the intimate nature of such a disclosure and the impact on the therapeutic alliance. The views of other mental health professionals would also be helpful in determining how others view TSD. Future samples should aim to be culturally diverse, given that ethnic minorities and other marginalised or oppressed individuals may have different needs in the therapeutic space and pertaining to TSD specifically.

Conclusions

In conclusion, this IPA study offers an interpretative account of what people who have undertaken psychological therapy for their mental health think about therapists who have had their own mental health difficulties and disclose these during therapy. Participants identified a range of experiences and views regarding their therapist disclosing their own mental health difficulties. These were identified as different dimensions of five constructs: what your disclosure says about me, the privilege of power, feeling conflicted, who is my therapist and inspiration and hope. This research offers a new contribution to the TSD literature, specifically around the sharing of the therapist's own mental health difficulties. It suggests that overall, this can be a positive experience for clients in terms of their own recovery and normalisation of their distress, whilst strengthening their relationship with their therapist so long as boundaries are preserved and the disclosure is sensitive to the characteristics of the client themselves. Power is paramount within any therapeutic relationship and extra consideration should be given to this when considering disclosure decisions, along with the therapist's inherent privilege over disclosure decisions compared to the clients.

References

Audet, C., & Everall, R. D. (2003). Counsellor self-disclosure: Client-informed implications for practice. *Counselling and Psychotherapy Research, 3,* (3), 223-231.

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24,* (2), 85-100.

Barrett, M. S., & Berman, J. S. (2001). Is psychotherapy more effective when therapists disclose information about themselves? *Journal of Consulting and Clinical Psychology*, *69,* (4), 597.

Barnett, M. (2007). What brings you here? An exploration of the unconscious motivations of those who choose to train and work as psychotherapists and counsellors. *Psychodynamic Practice, 13,* (3), 257-274.

Biggerstaff, D.L. (2003). Empowerment and self-help: a phenomenological methodology in research in the first year after childbirth. In J. *Henry (Ed) European Positive Psychology Proceedings* (pp 15-24). Leicester: British Psychological Society.

Bike, D. S., Norcross, J. C., & Schatz, D. (2009). Processes and outcomes of psychotherapists' personal therapy: Replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training, 46,* (1), 19-31.

Bridges, N. A. (2001). Therapist's self-disclosure: Expanding the comfort zone. *Psychotherapy: Theory, Research, Practice, Training*, *38,* (1), 21.

Brown, L. S., & Walker, L. (1990). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship* (pp.135-154). New York, NY: Plenum Press.

Clare, L. (2003). Managing threats to self: awareness in early stage Alzheimer's disease. *Social Science and Medicine, 57,* (6), 1017-1029.

Cushway, D. (1996). Tolerance begins at home: Implications for counsellor training. *International Journal for the Advancement of Counseling, 18,* (3), 189-197.

Cvetovac, M.E., & Adame, A.L. (2017). The wounded therapist: Understanding the relationship between personal suffering and clinical Practice. *The Humanistic Psychologist, 45,* (4), 348.

Elliott, D. M., & Guy, J. D. (1993). Mental health professionals versus non-mental-health professionals: Childhood trauma and adult functioning. *Professional Psychology: Research and Practice, 24,* (1), 83-90.

Farber, B. A., Manevich, I., Metzger, J., & Saypol, E. (2005). Choosing psychotherapy as a career: Why did we cross that road? *Journal of Clinical Psychology, 61,* (8), 1009-1031.

Gibson, M. F. (2012). Opening up: Therapist self-disclosure in theory, research, and practice. *Clinical Social Work Journal, 40,* (3), 287-296.

Goldfried, M. R., Burckell, L. A., & Eubanks - Carter, C. (2003). Therapist self-disclosure in cognitive behavior therapy. *Journal of Clinical Psychology, 59,* (5), 555-568.

Ham, C.C., LeMasson, K.D.S., & Hayes, J.A. (2013). The use of self-disclosure: Lived experiences of recovering substance abuse counsellors. *Alcoholism Treatment Quarterly, 31,* (3), 348-347.

Hanson, J. (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. *Counselling and Psychotherapy Research, 5,* (2), 96-104.

Health & Care Professionals Council. (2016). *Standards of Conduct, Performance, and Ethics.* London: HCPC.

Hill, C. E., Knox, S., & Pinto-Coelho, K. G. (2019). Self-disclosure and immediacy. *Psychotherapy Relationships That Work, 1*, 379.

Isaksson, A., Corker, E., Cotney, J., Hamilton, S., Pinfold, V., Rose, D., & Evans-Lacko, S. (2018). Coping with stigma and discrimination: evidence from mental health service users in England. *Epidemiology and Psychiatric Sciences*, *27*, (6), 577-588.

Ivey, G. and Partington, T. 2012. Psychological woundedness and its evaluation in applications for clinical psychology training. *Clinical Psychology and Psychotherapy. 21*, (2), 166-17.

Knaak, S., Szeto, A. C., Fitch, K., Modgill, G., & Patten, S. (2015). Stigma towards borderline personality disorder: effectiveness and generalizability of an anti-stigma program for healthcare providers using a pre-post randomized design. *Borderline Personality Disorder and Emotion Dysregulation*, *2*, (1), 9.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology*, *44*, (3), 274.

MacCulloch, T., & Shatell, M. (2009). ‘‘Reflections of a ‘wounded healer’’. *Issues in Mental Health Nursing*, *30*, (2), 135-137.

Mahalik, J. R., Van Ormer, E. A., & Simi, N. L. (2000). Ethical issues in using self-disclosure in feminist therapy. In M. M. Brabeck (Ed.), *Psychology of women book series. Practicing feminist ethics in psychology* (pp. 189-201). Washington, DC, US: American Psychological Association.

McConnaughy, E. A. (1987). The person of the therapist in psychotherapeutic practice *Psychotherapy: Theory, Research, Practice, Training, 24,* (3), 303-314.

McLeod, J. M., & Chaffee, S. R. (2017). The construction of social reality. In *The social Influence Processes* (pp. 50-99). Routledge.

Nahon, D., & Lander, N. R. (1992). A clinic for men: Challenging individual and social myths. *Journal of Mental Health Counseling*, *14,* (3), 405-16.

Nikcevic, A. V., Kramolisova-Advani, J., & Spada, M. M. (2007). Early childhood experiences and current emotional distress: What do they tell us about aspiring psychologists? *The Journal of Psychology: Interdisciplinary and Applied, 141,* (1), 25-34.

Norcross, J. C., & Guy, J. D. (2005). The prevalence and parameters of personal therapy in the United States. In J. D. Geller, J. C. Norcross, & D. E. Orlinsky (Eds.), *The psychotherapist's own psychotherapy: Patient and clinician perspectives* (pp. 165–176). New York, NY: Oxford. University Press.

O'Hara, D. J. (2011). Psychotherapy and the dialectics of hope and despair. *Counselling Psychology Quarterly*, *24*, (4), 323-329.

Peterson, Z. D. (2002). More than a mirror: The ethics of therapist self-disclosure. *Psychotherapy: Theory, Research, Practice, Training,* 39, (1), 21-31.

Picot, A., McClanahan, S., Conviser, J., Costin, C., Rabinor, J.R, Hornstein, R., McGilley, B.H. (2010). The therapist's appearance and recovery: Perspectives on treatment, supervision and ethical implications. Eating Disorders: *The Journal of Treatment and Prevention*, *18*, (2), 165-175.

Rabassa, M. (2009). *Clients' experience of therapist self-disclosure within a CBT context: an interpretative phenomenological analysis* (Doctoral dissertation, University of East London).

Rogers, C.R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin Company.

Schulze, B. (2007). Stigma and mental health professionals: a review of the evidence on an intricate relationship. *International Review of Psychiatry*, *19*, (2), 137-155.

Scior, K. (2017). *The HOP-MHP Project*. Retrieved from http://www.ucl.ac.uk/pals/research/cehp/stigmaresearch/documents/hop_docs/hop-mhp.

Sedgwick, D. (2016). *The wounded healer: Countertransference from a Jungian perspective*. Routledge.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and Health*, *11*, (2), 261-271.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ, US: John Wiley & Sons Inc.

Van Voorhis, R. M. (2017). Feminist theories and social work practice. In *Human Behavior Theory and Social Work Practice* (pp. 271-296). Routledge.

Wells, T. L. (1994). Therapist self-disclosure: Its effects on clients and the treatment relationship. *Smith College Studies in Social Work*, *65*, (1), 23-41.

Wright, M.O., Seltmann, L., Telepak, L.C., & Matusek, J.A. (2012). *Therapists as wounded healers: the impact of loss and past psychological problems on work with clients*. Manuscript in preparation.

Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer. *Psychotherapy*, *49*, (4), 482.

Zilcha-Mano, S., Roose, S. P., Brown, P. J., & Bret, R. R. (2018). Not just nonspecific factors: The roles of alliance and expectancy in treatment, and their neurobiological underpinnings. *Frontiers in Behavioral Neuroscience*, *29*, (12), 293.

Ziv-Beiman, S., & Shahar, G. (2016). Therapeutic self-disclosure in integrative psychotherapy: When is this a clinical error? *Psychotherapy*, *53*, (3), 273.

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice*, *40*, (1), 22-30.

Appendices

Word Count: 7,862

Appendix A: Author Guidelines for Journal of Mental Health.

This document has been shortened, but the full document can be retrieved from: **https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=ijmh20**

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper.

The total word count for Review Articles should be no more than 6000 words. All other articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. Manuscripts are limited to a maximum of 4 tables and 2 figures.

Style Guidelines

Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in Word format. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting template(s).

Word templates are available for this journal. Please save the template to your hard drive, ready for use.

If you are not able to use the template via the links (or if you have any other template queries) please contact us here.

References

Please use this reference guide when preparing your paper. An EndNote output style is also available to assist you.

Appendix B: Study Approval from the University of Liverpool Clinical Psychology Research Review Committee.

D.Clin.Psychology Programme
Division of Clinical Psychology
Whelan Building, Quadrangle
Brownlow Hill
LIVERPOOL
L69 3GB

Tel: 0151 794 5530/5534/5877
Fax: 0151 794 5537
www.liv.ac.uk/dclinpsychol

16 November 2017

Anna Bridge
Clinical Psychology Trainee
Doctorate of Clinical Psychology Doctorate Programme
University of Liverpool
L69 3GB

RE: What do people who have undertaken psychological therapy for their mental health think about therapists who have their own mental health difficulties?
Trainee: Anna Bridge
Supervisors: Ste Weatherhead and Hannah Wilson

Dear Anna,

Thank you for your response to the Chair's comments of your research proposal submitted to the D.Clin.Psychol. Research Review Committee (letter dated 14/11/2017).

Your amended proposal (version number 3, dated 14/11/2017) has been reviewed by the Committee Chair.

The trainee is advised to consider in her timeline when she is planning on submitting a draft literature review to her supervisors.

I can now confirm that your amended proposal (version number 3, dated 14/11/2017) meets the requirements of the Committee and has been *approved* by the Committee Chair.

Please take this Chairs Action decision as ***final*** approval from the committee.

You may now progress to the next stages of your research.

I wish you well with your research project.

Dr Catrin Eames
Vice-Chair D.Clin.Psychol. Research Review Committee.

Appendix C: Study Approval from the University of Liverpool Research Ethics Committee.

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

10 May 2018

Dear Dr Weatherhead

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	2723
Project Title:	What do people who have undertaken psychological therapy for their mental health think about therapists who have their own mental health difficulties?
Principal Investigator/Supervisor:	Dr Stephen Weatherhead
Co-Investigator(s):	Miss Anna Bridge
Lead Student Investigator:	-
Department:	School of Psychology (including DClinPOsych)
Approval Date:	10/05/2018
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

- All serious adverse events must be reported via the Research Integrity and Ethics Team (ethics@liverpool.ac.uk) within 24 hours of their occurrence.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the research, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form using the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Health and Life Sciences Research Ethics Committee (Psychology, Health and Society)

iphsrec@liverpool.ac.uk

0151 795 5420

Appendix D: Social Media Advertisement

Social Media Advertisement Version 1, 14th November, 2017.

Title of Study

'What do people who have undertaken a psychological therapy for their mental health think about therapists who have their own mental health difficulties?

My name is Anna Bridge and I am trainee clinical psychologist on the Doctorate in Clinical Psychology programmer at the University of Liverpool. I am carrying out this study as part of my training.

What is the study about?

The purpose of the study is to understand what people who have experienced mental health difficulties think about therapists who share their own mental health difficulties during therapy. To take part you must 18 or over and have received a psychological therapy for a mental health difficulty. During the therapy your therapist must have shared with you information about their own mental health difficulties. You must not have been a therapist yourself and must not be currently accessing therapy.

What does the study involve?

If you decide to take part you will be asked to attend an interview with myself which would last around one hour and would be recorded and transcribed (typed up). I would ask you questions about how you felt about knowing your therapist had experienced mental health difficulties and them sharing these with you during your therapy. The interview would take place at the University of Liverpool, a community center or if you are currently accessing mental health services then I can visit you at home.

I am able to recruit people who can be interviewed in North West England, specially Merseyside, Cheshire, Manchester, Lancashire, and Cumbria. I may also be able to recruit people from other areas in the UK, so please get in touch and we can discuss this.

Should you take part, you will be reimbursed with a £10 Love to Shop Voucher.

If you would like a participant information sheet with more information about the study or have any further questions, please contact Emily Joseph, Research Administrator at the University Of Liverpool on 0151 794 5102. Alternatively, you can email me at anna1983@liverpool.ac.uk.

Thank you for taking the time to read this.

Appendix E: Poster Advertisement

Poster Advertisement, 14th November, 2017

‘Therapists have struggles too’

What do people who have undertaken a psychological therapy for their mental health think about therapists who have their own mental health difficulties?

Have you received a psychological therapy for your mental health? Did your therapist share their own mental health difficulties with you during therapy? If so, and you would be happy to talk about your experience of this, please get in touch using the email below.

To take part you must;

- **Be over 18**
- **Have received a psychological therapy for your mental health**
- **Not currently be having therapy**
- **Be able to speak fluent English.**
- **Not be, or have been a therapist yourself**

The study involves;

- **An interview lasting around an hour**
- **Completing a short demographic questionnaire**
-

The research is being undertaken at the University of Liverpool by Anna Bridge, Trainee Clinical Psychologist. If you have any questions or want to discuss the study, then please contact Anna on anna1983@liverpool.ac.uk.

Everyone will receive a £10 Love to Shop Voucher at the end of their interview.

Appendix F: Participant Information Sheet (Version 3, 9th July, 2018) Study ID Number:

Participant Information Sheet

Title of Study: 'What do people who have undertaken a psychological therapy for their mental health think about therapists who have their own mental health difficulties?

My name is Anna Bridge. I am a trainee clinical psychologist carrying out this study for my doctoral training. It has been approved by the University of Liverpool Research Ethics Committee and is sponsored and insured by the University of Liverpool.

What is the purpose of this study?

The study aims to understand what people who have experienced mental health difficulties think about therapists who share their own mental health difficulties during therapy. Understanding how clients feel about their therapist sharing their own mental health difficulties will help therapists to think about how sharing such difficulties may affect their clients.

Who will be involved in the study?

Participation is voluntary. You must be 18 or over and have undertaken a psychological therapy for your mental health where your therapist shared their own mental health difficulties and be able to talk about this. You must not have been a therapist yourself or be currently accessing therapy.

What counts as a mental health difficulty?

A 'mental health difficulty' is defined as a health condition that changes a person's thinking, feeling, and behaviour, causes the person distress, difficulty in functioning, and requires psychological or psychiatric support. Your therapist must have shared with you that they received psychological or psychiatric treatment or help, or medication for their difficulties.

What will be expected of me if I agree to take part?

The interview will take around an hour, be audio recorded and take place at the University of Liverpool/a community centre or at your home if you prefer. Should you want a home visit, you will need to be under a mental health service and I will need your consent for me to contact the service to obtain information I may need prior to the visit. I will ask about your therapist sharing their mental health difficulties with you, but not personal details about yourself, your therapist or the service. You will also be asked to complete a short questionnaire about yourself, your therapist and the therapy (type, length etc.)

Reimbursement

You will be reimbursed with a £10 'Love to Shop' voucher at the end of your interview for taking part in the study.

What will happen to my information?

The University processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The [Principal Investigator / Supervisor] acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to Dr Stephen Weatherhead (see contact details at end of sheet).

Further information on how your data will be used can be found in the table below.

How will my data be collected?	Your data will be collected by a face to face interview and using a demographic questionnaire.
How will my data be stored?	Your interview will be held on a secure file on the University of Liverpool's computer network. Your transcript will be typed up (transcribed) using a secure transcription server and stored securely at the University of Liverpool or the researcher's home address (along with your demographic questionnaire), separately from your consent form.
How long will my data be stored for?	For a minimum 10 years, in line with the University of Liverpool's guidelines.
What measures are in place to protect the security and confidentiality of my data?	None of your personal details will be used in the transcription or on your demographic form. There is the possibility that you may meet the researcher in a different role in the future, and so confidentiality will be maintained throughout the study and in the future.
Will my data be anonymised?	Yes, your interview and demographic form will be kept confidential using a study ID number.
How will my data be used?	The study will be written up and submitted for publication in an academic journal, which may include confidential quotes from your interview, with your consent. You will be asked whether you would like to receive a copy of the results, once published. Findings of the research may also be shared in other ways, such as conference presentations.
Who will have access to my data?	Either of my supervisors and other authorised researchers, to support further research.
Will my data be archived for use in other research projects in the future?	Yes, again this will remain confidential.
How will my data be destroyed?	After 10 years, your data will be destroyed in line with the University of Liverpool's Records Management Policy and disposed of using their

	confidential waste system.

What if I want to withdraw from the study?

Withdrawal from the study can happen at any point up until 7 days after the interview without providing a reason, as after this time interview data may have been transcribed and incorporated into the analysis. Withdrawal will not affect the standard of care you receive from healthcare services.

What happens if I become distressed as a result of participating in the study?

Participation may involve talking about potentially distressing experiences related to your own or therapist's mental health. You will be able to take breaks or stop the interview altogether. You will be provided with services you can contact should you require additional support. If needed, I can also pass information to your GP (you will need to share contact details of your GP in order to participate in the study). If the researcher becomes concerned about either your own or your therapist's mental health, then confidentiality cannot be guaranteed. The researcher will always speak with you first about this, before deciding with you how best to move forward should this happen.

What if I am unhappy or there is a problem?

If you wish to complain or have any concerns about the way you have been treated whilst participating in this study, then you can contact the Chief Investigator Dr Stephen Weatherhead between 9am and 5pm on 0151 494 5102 or at ste@liverpool.ac.uk. You can also contact the Research Governance Officer, Matthew Billington on 0151 794 8290 or at ethics@liv.ac.uk. Please provide the name (or details) of the study and names of the researcher or supervisors.

Further Information and Contact Details

Thank you for your time. If you would like to participate or have any further questions please contact me using the details below.

Researcher

Anna Bridge
Trainee Clinical Psychologist
Doctorate in Clinical Psychology, University of Liverpool, Ground Floor, Whelan Building Quadrangle, Brownlow Hill, Liverpool. L69 3GB.
Email: anna1983@liverpool.ac.uk

Supervisors

Dr Stephen Weatherhead
Senior Academic and Clinical Tutor, Clinical Psychologist
Doctorate in Clinical Psychology, University of Liverpool, Ground Floor, Whelan Building Quadrangle, Brownlow Hill, Liverpool. L69 3GB.
Email: ste@liverpool.ac.uk

Dr Hannah Wilson
Clinical Psychologist and Senior Clinician
Central & West Lancashire Eating Disorder Service
Lancashire Care NHS Foundation Trust
Email: Hannah.Wilson@lancashirecare.nhs.uk

Appendix G: Participant Consent Form (Version 3, 9th July, 2018).

CONSENT FORM

Project Title: What do people who have undertaken psychological therapy for their mental health think about therapists who have their own mental health difficulties?

Researcher: Anna Bridge, Trainee Clinical Psychologist

Supervisors: Dr Stephen Weatherhead, Clinical Psychologist

Dr Hannah Wilson, Clinical Psychologist

If you are happy to participate please complete and sign the consent form below

Please initial box

1. I confirm that I have read and understand the information sheet (Version 3) for the above study and have had the opportunity to ask questions.	
2. I understand that my participation in the study is voluntary, and that I am free to withdraw at any time up until 7 days after the interview without giving a reason and without detriment to any treatment/service. I understand that I am free to decline or answer any questions.	
3. I understand that taking part in the study involves an audio recorded interview and completion of a short demographic questionnaire.	
4. I agree that any data collected may be reviewed by the research team and they may listen to audio recordings.	
5. I understand that the information I provide will be fully anonymised with an ID number, held in line with data protection requirements at the University of Liverpool, and may be shared with other authorised researchers to support further research until it is disposed confidentially.	
6. I understand that my signed consent form will be stored separately from my interview and demographic form and stored securely at the University of Liverpool.	
7. I agree to the use of anonymised quotes in publications.	
8. I agree to provide the researcher with the contact details of my GP so that they can contact them should any issues around risk arise.	
9. I understand that confidentiality cannot be guaranteed if the researcher becomes concerned about either my own or my therapist's mental health but will speak with me first about this before deciding how to move forward.	
10. I understand that I will receive a £10 voucher for taking part in the study	
11. I give permission for the researcher to contact me by telephone or email following my interview to ask further questions or clarify any issues raised (optional).	
12. I would like to receive a copy of my interview transcript (optional)	
13. I would a summary of the study's findings following its submission and approval (optional)	

I agree to take part in the above study

_____ _____ _____

Name of participant	Date	Signature
Researcher	Date	Signature

Appendix H: GP/Healthcare Provider Consent Form

Consent to contact GP/Healthcare Providers Form
Version 1, 14th November, 2017 Study ID Number:

Consent to contact GP and Healthcare Providers Form

I give permission for the researcher to contact my GP/and or other health care provider (s) to obtain any relevant information that the researcher may need in order to visit me at home.

Name of participant	Date	Signature
Researcher	Date	Signature

Contact details of GP/Healthcare Provider

Name: _____

Address: _____

Telephone Number: _____

Participant Contact Details (*to be detached, stored securely and kept separate from consent form. This will be destroyed once the study is complete*).

Name: _____

Email Address _____

Telephone Number: _____

Preferred Contact Method: Email/Phone/Text (please circle)

Appendix I: Interview Topic Guide

Interview Guide Version 1, 14th November, 2017

Interview Guide

This guide is intended to facilitate a conversation about the topic of interest. It is not a structured series of questions to be asked and will utilised flexibly according to the participant's responses.

Checklist of things to be covered prior to the interview:

Introductions:

Explanation of research:

Confidentiality revisited:

Opportunity to ask questions:

Demographic Questionnaire (or to be completed at the end, dependant on participant's preferences):

Participants will be asked to talk freely about their experiences which they consider to be important or personally relevant for them regarding their experience of their therapist sharing their own mental health difficulties with them during therapy.

The content of the interview will be dictated by the participant and the following questions will be used with prompts if they are not covered naturally in the course of conversation.

Opening Question:

Now that you have read the information leaflet and had a chance to ask any questions, can you tell me about your experiences of therapy when your therapist disclosed their own mental health difficulties?

Questions to follow:

1) Did you have any thoughts or feelings about having therapy?
2) Did you have any thoughts or feelings about seeing a therapist?
3) Can you describe how your therapist shared their own mental health difficulties with you?
4) How did you feel knowing your therapist had experienced mental health difficulties?
5) Did this influence the way that you viewed them?
6) How was your relationship with your therapist after they shared their mental health difficulties with you?
7) What was your experience of the therapy?
8) How do you feel about therapists who have mental health difficulties?

Prompts (where appropriate)

How did you feel about that?

What was that like for you?

What were you thinking?

How did you make sense of or understand that?

Is there anything else you feel you want to say about that?

How did you understand that at the time?

How do you understand that now?

Appendix J: Participant Debrief Sheet

Participant Debrief Sheet
Version 1, 14th November, 2017 Study ID Number:

Participant Debrief Sheet

Thank you for taking the time to participate in this study. If the study has caused you distress in anyway, there are a list of services at the bottom of this page that can offer support. Alternatively, you may want to contact your GP.

If you wish to complain or have any concerns about the way you have been treated whilst participating in this study, then you can contact the Chief Investigator Dr Stephen Weatherhead between 9am and 5pm on 0151 494 5102 or at ste@liverpool.ac.uk. You can also contact the Research Governance Officer, Matthew Billington on 0151 794 8290 or at ethics@liv.ac.uk. Please provide the name (or details) of the study and names of the researcher or supervisors.

The Samaritans

Free emotional support over the telephone 24 hours a day, 365 days a year.

Tel: 116 123 (UK)

Email: jo@samaritans.org

MIND

Information provided on a number of topics, including:

- Types of mental health difficulties
- Where to get help
- Medication and alternative treatments
- Advocacy

Tel: 0300 123 3393 (lines open Monday to Friday, 9am – 6pm, except bank holidays).

Email: info@mind.org.uk

SANE

Specialist mental health helpline offering emotional support to anyone affected by mental health difficulties, including family, friends and carers.

Tel: 0300 304 7000 (lines open 4.30pm – 10.30pm, 365 days a year).

Thank you for taking the time to read this debriefing sheet. Please keep it for future reference.

Appendix K: Participant/Therapist Demographic Questionnaire (adapted from Audet & Everall, 2010[1]).

Participant Characteristics (please tick the box on left hand side)	**N**
Age Range ¤ 18 – 30 ¤ 31 – 40 ¤ 41 – 50 ¤ 51 – 60 ¤ 60 and over ¤ Prefer not to say	
Gender ¤ Female ¤ Male ¤ Transgender Female ¤ Transgender Male ¤ No Binary/Non - Conforming ¤ Other (please state)…… ¤ Prefer not to say	
Ethnicity ¤ Asian or Asian British: Bangladeshi ¤ Asian or Asian British: Chinese ¤ Asian or Asian British: Indian ¤ Asian or Asian British: Pakistani ¤ Asian or Asian British: Other Asian ¤ Black or Black British ¤ Hispanic/Latino ¤ Gypsy/ Traveller/ Irish Traveller ¤ Mixed or Mixed Multiple ¤ White or White British ¤ Other (please state)…… ¤ Prefer not to say	
Occupation ¤ Full time employment (please state)……. ¤ Part time employment (please	

[1] Audet, C.T., & Everall, R.D. (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective. *British Journal of Guidance and Counselling, 38*, 327 – 342.

state)……..	
¤ Retired	
¤ Student	
¤ Unemployed/looking for work	
¤ Unemployed/not looking for work	
¤ Other (please state)…….	
¤ Prefer not to say	
Was it your first time in therapy when therapist shared their difficulties with you?	
¤ Yes ¤ No ¤ Prefer not to say	
If no, how many times have you been in therapy before?	
¤ Once ¤ Twice ¤ Three times ¤ More than three times ¤ Prefer not to say	
Therapist Characteristics	
Therapist's mental health difficulties shared (please tick all that apply)	
¤ Anxiety ¤ Bipolar/Mood difficulties ¤ Body Image ¤ Depression/low mood ¤ Delusions ¤ Eating Disorder ¤ Hearing voices/hallucinations ¤ Interpersonal/Social ¤ Obsessive Compulsive Disorder ¤ Paranoia ¤ Personality difficulties ¤ Phobia ¤ Psychosis ¤ Self-harm ¤ Substance Misuse ¤ Trauma/PTSD ¤ Unresolved grief/loss ¤ Other (please state)…….	
Type of therapist	
¤ Counsellor ¤ Psychiatrist	

⌑ Psychologist ⌑ Psychotherapist ⌑ Other (please state)…….. **Gender** ⌑ Female ⌑ Male ⌑ Transgender Female ⌑ Transgender Male ⌑ No Binary/Non - Conforming ⌑ Other (please state)…… ⌑ Prefer not to say ⌑ Unsure	
Therapy Characteristics **Model of Therapy** ⌑ Cognitive Analytic Therapy (CAT) ⌑ Cognitive Behavioural Therapy (CBT) ⌑ Counselling ⌑ Integrative Therapy ⌑ Narrative Therapy ⌑ Psychodynamic Therapy ⌑ Solution Focused Therapy ⌑ Other (please state)…….. ⌑ Unsure **At which point in therapy was the disclosure made?** ⌑ 1 – 4 sessions ⌑ 5 – 8 sessions ⌑ 9 – 12 sessions ⌑ 13 – 16 sessions ⌑ Over 16 sessions ⌑ Unsure **Do you hold any religious or spiritual beliefs?** ⌑ Yes ⌑ No ⌑ Prefer not to say **If yes, please state what they are here, or if you would prefer not to say, please tick this box** ⌑ ……	

Appendix L: Example Transcript with Emergent Themes **(Removed)**

Appendix M: Extract from reflexive diary. (Removed)